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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

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Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS†

MEDICAL PREPAREDNESS: MILITARY; CIVILIAN; RED CROSS

United States Has the Lowest Morbidity and Mortality Rates.—Morbidity and mortality rates in the United States for years have been lower than those of any European or other nation. Therefore it may be taken, as a sound conclusion, to affirm that the "preparedness" of physicians in the United States is of a high standard, because otherwise such statistics would not obtain, since climatic, industrial, and various conditions here are not greatly superior to those of other lands.

The above comment relates to what has been accomplished in days of peace by the American medical profession in the preventive and healing activities of medicine. The record may be taken as a token of what still may be expected from physicians in times of emergency or war—whichever term may be the more appropriate under existing conditions.

* * *

Effect of Selective Service Act on Private Medical Practice.—When Congress passed the Selective Service Act to bring into somewhat sudden being an army of 1,400,000 men, as provided in the Selective Service Act, it was certain that there would follow important results to civilian medical practice. For at once, step by step, as the induction of men as soldiers took place, there was also necessitated the induction of medical officers and personnel to look after the physical and mental well-being of those soldiers.

A few years ago, the massiveness of the present military set-up of the United States was not a subject of contemplation by the great majority of citizens, physicians included. However, an emergency has arisen that has been as great a surprise to physicians as to others.

For many medical men the new conditions meant a radical rearrangement of preëxisting plans of professional life and activities. Yet, in spite of this, the medical profession has not been found wanting. Through their national, state and county organizations, and also as individuals, doctors of medicine have met the call that has come to them. Those who have been inducted into service are now busily engaged in acquainting themselves with their new duties, even though existing military

†Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

routine, to many of them, is far distant from the busy professional lives that until recently were part of their daily living and responsibilities.

* * *

American Medical Association Met Its Responsibilities.—When the present emergency arose, far-sighted leaders in the American Medical Association—many of who had seen active service in Word War I—were quick to appreciate that the general staffs of the military forces of the Union were not in possession of the information that would permit them to proceed in a big way to place medical men who were to be inducted into service into places where each could be of greatest service. In this emergency the American Medical Association, through an expenditure of some $50,000 of its own funds, voluntarily gathered the needed information concerning physicians and made the same available to the Government! This was a great service, not yet appreciated by the people at large.

The medical profession, as a fact, has fully cooperated, not only in using its best efforts to provide medical staffs for the Army and Navy, but in having its members give a tremendous amount of gratuitous service as volunteer examiners for the local Selective Service Boards.

* * *

Obligations of Organized Medicine in Local Communities.—Organized medicine, through the state and component county societies, may take a justifiable pride in the record of service so well rendered by its members, but these organizations have an additional obligation to physicians who have been inducted into service, and whose personal and financial arrangements have received, in many cases, distinct shocks. That is why the California Medical Association will excuse military members from payment of State Association dues, and why component county societies, which have not yet taken similar action, should consider such action. It would be gratifying, indeed, if it could be stated that each of the forty component county units comprising the California Medical Association had made such provision.

Of course, the full story has not yet been told, and it is possible—should certain events arise in the international world—that still further changes and inductions into military service may be necessary. It is well for all to keep this possibility in mind.

* * *

A New Activity: "Civilian Defense."—At the time the Selective Service Act became operative, and more and more physicians were laying the obligations of private practice aside, attention was called to the increased responsibilities of those physicians who would remain behind, and upon whom must devolve the care of the civilian population. Special stress was placed upon the importance of maintaining, in good health, men and women who were engaged in the so-called essential industries—those from which the supplies were to be secured that would permit Army and Navy to function with greatest efficiency. The importance of proper care of these civilians was emphasized, since the maintenance of morale of soldiers, in camp or at the front, will depend, in considerable degree, upon freedom of worry concerning folks left at home.

Since then, by announcement from the President of the United States, the "Office of Civilian Defense" has been brought into being, with Mayor F. H. La Guardia of New York City as "U. S. Director, Civilian Defense," in charge.*

That newly created department of the National Government aims to bring into operation civilian forces which will be of aid in case our country becomes actually engaged in war. In the October issue of CALIFORNIA AND WESTERN MEDICINE, on page 207, comment was made concerning the national and regional offices of this activity, which has offices in Washington, D. C., and also for this regional area (one and the same as the Ninth Army Corps Area) in San Francisco.

Californians who are interested should write to the Ninth Civilian Area at 233 Sansome Street, San Francisco (Wallace Hunt, M. D., in charge), for further information in regard to Civilian Defense plans.

* * *

American Red Cross and Civilian Defense.—Physicians and others who are interested in American Red Cross activities are requested to refer to the communications in this number of the OFFICIAL JOURNAL, which are given on page 276, in which an official announcement appears delineating the scope of the respective activities: "Office of Civilian Defense" and "American Red Cross." A perusal of the letters there appearing will enable physicians to orient themselves and be able to give more accurate information.

FEDERAL REHABILITATION PROGRAM: HOW FAR WILL IT GO?

President Roosevelt's Pronouncement.—Under the alluring caption, "Army to Salvage 200,000 Men," Washington press dispatches have told us that President Franklin Delano Roosevelt had announced a plan to "salvage the equivalent of thirteen divisions of troops by curing physical defects of 200,000 rejected draftees." The Associated Press item of October 10 stated further:

> At his press conference the President said that figures from General Louis B. Hershey, director of selective service, showed that 900,000 of the first two million men examined were found to be physically or mentally unfit.
>
> Of this number it is estimated that 200,000 can be made fit for full active duty. Of the remainder, it is estimated that more than half can be restored to health sufficient to enable them to perform limited military service. Others suffering from mental, nervous, heart and lung diseases and muscular-skeletal diseases will not be considered for any type of Army duty, the President declared.
>
> One hundred thousand of the rejected men were turned down because they lacked the equivalent of a fourth grade education. This problem, he said, was primarily a state and local one.
>
> As for the health rehabilitation program, present plans call for the men to be treated by their local physicians and dentists, who would be paid by the Federal Government at rates to be set by the American Medical Association and the American Dental Association.

* In Letters department, in this issue, see communications on page 276.

Data From World War I.—The information contained in the above should have a real appeal to physicians, for it is to be hoped that the sentiments so well expressed will be carried through to fruition. The basic facts concerning physical deficiencies of a large proportion of Americans have been well known to physicians, the data having been of special record in connection with medical examinations made during World War I. However, when that struggle came to an end, all the emotional disturbance arising from such disturbing medical statistics promptly subsided; the governing authorities in federal and state legislation activities then promptly turning their attention to matters of immediate political importance and expediency.

To remind ourselves, let us glance at some of the World War I and present-day Selective Service figures since, certainly, to physicians, at least, they have particular interest:

Kimball detailed the causes of rejection for the 1918 draft as follows:

Causes for Disqualification	*Percentage*
1. Skin and teeth	3
2. Unclassified defects, including respiratory diseases, other than tuberculosis	4
3. Nose and throat, including bad tonsils, sinus trouble, hay fever, etc.	5
4. Tuberculosis of bone or lungs	5
5. Venereal diseases, *i.e.*, syphilis or gonorrhea	5
6. Nervous and mental, including St. Vitus dance, as well as mental deficiencies	6
7. Glandular defects in various glands, resulting in underweight in half of the cases, underheight, curvature of spine, and goiter	10
8. Cardiovascular diseases and defects affecting heart or blood vessels	10
9. Sense organs, one-half in the eye, one-half in hearing, speech, etc.	12
10. Mechanical defects in bony structure of body, resulting in weak joints, hands, or feet (Weak or flat feet were by far the most important)	40
	100

"In 1918, 486 out of every 1,000 men examined were rejected, which is 48.6 per cent.

* * *

Selective Service Statistics of 1940.—As of even date with President Roosevelt's rehabilitation pronouncement, United Press dispatches gave statistics, submitted by Brigadier General Lewis B. Hershey, Director of Selective Service—who analyzed the causes of 1940 rejections—as follows:

Causes of Disqualification	*Percentage*
a. Dental defects, 188,000 cases	20.9
b. Defective eyes, 123,000 cases	13.7
c. Cardiovascular diseases, 96,000 cases	10.6
d. Musculoskeletal defects, 61,000 cases	6.8
e. Venereal cases, 57,000	6.3
f. Mental and nervous diseases, 57,000 cases	6.3
g. Hernia, 56,000 cases	6.2
h. Defects of ears, 41,000 cases	4.6
i. Defects of feet, 36,000 cases	4.0
j. Defective lungs, including tuberculosis, 26,000 cases	2.9
k. Miscellaneous, 159,000 cases	17.7

How Government Proposes to Proceed.—Director of Selective Service General Hershey, stated further:

"The registrant will have the privilege of having the services performed by his family physician or dentist in his own community.

"The cost of this rehabilitation program will be borne by the Federal Government as a necessary part of our national defense program, and additional funds will be made available to the selective service system for this purpose."

President Roosevelt disclosed that plans already are well advanced for the salvage program. In cases of heart and musculoskeletal diseases, as well as mental and nervous cases, persons considered by local boards as being susceptible to rehabilitation will be placed in a special selective service category.

Remaining under orders of their selection boards, these men then will be visited by traveling boards or "teams" of outstanding specialists, who will examine them and recommend curable cases for immediate treatment at Government cost.

* * *

Gratuitous "Examination" Work Should Not Include "Treatment."—All the above is most interesting, especially to members of the medical profession.

In this connection, however, it may not be amiss to refer to the last annual session of the California Medical Association, at which one of the military representatives, only recently inducted from civil practice, took occasion in his paper to criticize members of the medical profession for not more generously going into service. At a subsequent club meeting, at which the same speaker criticized volunteer medical examiners for not removing hard wax plugs from ears, etc., his attention was called to the fact that medical examiners on Selective Service Boards had volunteered to examine selectees, and that an examination was not synonymous with treatment.

Mention is made of this to bring out the point that it should not be a matter of surprise when lay persons become confused concerning the fields of diagnosis and treatment, since medical graduates themselves sometimes commit a similar error.

* * *

No "Below-Cost Fee Tables" Should Be Sanctioned.—Following the original dispatches referred to above, no news items concerning the basis of remuneration for the rehabilitation treatments, so prominently publicized, have been noted. So again the hope may be expressed that the medical profession will not continue to commit one of its egregious errors by announcing and publicizing fee tables with rates far below those of established custom; and such as have been found to be necessary if the physician is to maintain himself and his family in proper station, and be fitted to carry on the responsibilities constantly confronting him in his work.

Almost every day, in the press, statements are given, with more or less praise, that this, that, or some other major manufacturing or construction organization will do certain work at cost, plus only 10 per cent. Labor, also, through its organized agencies, seeks always to keep the incomes of its members in harmony with rising costs. Physicians, however, by contrast, are prone to promulgate fee

tables for services which fail to take into account office rent, clerical aid and other phases of upkeep. In every such instance, a fee table is given publicity that leads many former and prospective patients to believe that the fees requested from them later on are exorbitant. The reward for overgenerous action is, therefore, not good-, but ill-will.

It is true that in emergencies confronting our country we should give without stint. It is not necessary, however, for physicians, by way of example, to compensate themselves at less than cost values, to the detriment, not only of their to-days, but of the days to come. Meaning, when transposed, nothing more nor less than this, that if the Federal and State Governments wish to subsidize rehabilitation work for selectees who have been rejected because of physical defects, the compensation to physicians should be adequate; that is, of amount to cover all costs involved, plus that small margin of net return that will permit the physician or surgeon to have at least a moderate compensation for his endeavors to make a citizen having defects again efficient to his country, from both the "utilitarian" and a "military" aspects.

HOSPITAL SERVICE INSURANCE: A STATEMENT OF C. M. A. POLICY

Action of the Council of the California Medical Association.—In this issue, on page 255, are given the minutes of the 296th meeting of the California Medical Association Council, held in Los Angeles on October 26, 1941. It is to be hoped that the account of the proceedings will be read, not only by the officers of component county societies, but that most of the members will also take the time to scan them, since matters of importance concerning both scientific and organized medicine appear therein.

* * *

Text of the "Statement of Policy."—Of special interest to members of the California Medical Association is Item 9 of the minutes, on page 256, with its presentation of the conditions laid down by the California Medical Association for observance by hospital service organizations, before their policies or contracts may be given approval.

Request is made that members read this statement, since its proper execution implies the full coöperation of all concerned. Statement follows:

"HOSPITAL SERVICE INSURANCE

"A Statement of Policy issued by the California Medical Association, October 26, 1941

"The California Medical Association has consistently endorsed the principle of hospital service insurance and, upon request, the Council of the California Medical Association has given its approval to some or all of the activities of local hospitalization associations. The California Medical Association recommends only those hospital contracts which provide straight hospital services. It does not give, and it never has given approval to any contracts which provide medical benefits or services as a part of hospital services. It does not object to the provisions of limited diagnostic medical services (x-ray and laboratory) along with hospital benefits, provided that these are arranged for on some ethical and legal basis, such as reimbursement or indemnification. The following points are therefore emphasized:

"1. The California Medical Association approves hospital service insurance associations which issue straight hospital service policies (for example: the hospital contract issued by Hospital Service of California and the Associated Hospital Service of Southern California in conjunction with California Physicians' Service).

"2. It does not recommend any hospitalization contract which provides diagnostic x-ray, laboratory or other medical services as hospital benefits. These are medical benefits and may only be issued on an indemnification or medical service basis.

"3. When hospital service insurance associations issue hospital service contracts which include indemnification for diagnostic medical services, it is desirable that such be specified in the description of the contract (for example: Hospital service contract and limited professional service contract). Further, it is desirable that the association issuing such contracts make specific arrangements whereby the fees for radiology or pathology are payable to the physician rendering those services, or jointly to the physician and subscriber (in which case the subscriber can endorse the check over to the physician rendering the service). In this manner the hospitalization association will be complying with the letter as well as the spirit of indemnification.

"4. The California Medical Association emphasizes that it does not approve or endorse any hospital service contracts which purport to provide any medical services as a part of hospital services, nor can it countenance the issuance by any hospitalization association of advertising literature which does not indicate that payment for medical services is being made to physicians rendering such services. It is important for the welfare of the public, the hospitals and the medical profession that a clear distinction be made between hospital service and medical service in any and all of these hospitalization insurance contracts."

SOME REMARKABLE LETTERS: INVOLVING THE CALIFORNIA STATE COMPENSATION INSURANCE FUND

Council's Consideration of the Letters, and Decisions Thereon.—On October 26, the Council of the California Medical Association held its quarterly meeting in Los Angeles. The minutes of the proceedings appear in this number of the OFFICIAL JOURNAL. The Council voted that the attention of members be specifically called in the editorial department to *Item 11—California State*

Compensation Insurance Fund: Some Testimonial Correspondence (see page 257), and to letters submitted therewith.

The action taken by the Council, as given in Item 11, is indicated in the following:

(Copy)

"CALIFORNIA STATE COMPENSATION INSURANCE FUND: SOME TESTIMONIAL CORRESPONDENCE

"(*a*) *Presentation of Copies of Certain Letters.* The attention of the Council was called to certain communications that had been circularized to members of the medical profession by the Wilshire Medical Laboratories of Los Angeles, as follows:

"(1) A photostatic copy of a letter bearing the signature of John C. Stirrat, manager of the State Compensation Insurance Fund; and

"(2) An appeal that laboratory work needed for injured employees be sent to said laboratory.

"After consideration of the same and other evidence, upon motion duly made and seconded, it was voted that the Council agreed that the Manager of the State Compensation Insurance Fund has exhibited unwarranted favoritism in favor of said laboratory, thus discriminating against many equally or better qualified laboratories.

"Further, the Council of the California Medical Association considers compliance with the suggestions contained in the photostatic copy of the letter dated August 22, 1941, and signed by the Manager of the State Compensation Insurance Fund, to be beneath the dignity of the members of the California Medical Association.

"The Council also expresses its unqualified disapproval of this campaign of solicitation by a state official on behalf of a private institution, ignoring as he has done, many competent, medically directed laboratories in Los Angeles and vicinity, in addition to the attempted use of political influence in relation to the medical care of the unfortunate victims of industrial accidents.

"(*b*) *Instructions to Executive Committee to Call Attention of Certain State Officials to Pertinent Correspondence.*—After further discussion, on motion duly made and seconded it was voted that the Executive Committee be directed by the Council, within fourteen days, to formulate a protest embodying the sentiments included in the aforesaid resolutions, and as brought out in the discussion on the evidence presented; and that copies of such protest be forwarded to His Excellency, Governor Culbert Olson, Mr. John C. Stirrat, manager of the State Compensation Insurance Fund, the Industrial Accident Commission, the State Compensation Insurance Fund, and other interested State agencies, such protest to have attached copies of the photostat letters bearing the signature of Mr. Stirrat, and the two enclosures from the Wilshire Medical Laboratories; and further, that the action taken by the Council be published in the editorial section of the next issue of CALIFORNIA AND WESTERN MEDICINE.

Letters referred to above, follow:

(Copy: Letter No. 1)

(COPY OF PHOTOSTAT)

WILSHIRE MEDICAL LABORATORIES
X-RAY AND CLINICAL
2016 Wilshire Boulevard, Los Angeles, California
Telephone DRexel 1235

August 29, 1941.

Dear Doctor:

Enclosed please find photostatic copy of letter to us from Mr. John C. Stirrat, Manager of the State Compensation Insurance Fund, which is self-explanatory. In order that you may be enabled to conform to his request, we are enclosing blanks for referring patients of the State Fund to us.

We are also enclosing Doctor's Fee schedule for both x-ray and clinical laboratory procedures which would apply to your private practice, in the event you desire to refer this work to us in addition to the State Fund's x-ray and clinical laboratory examinations.

We wish to assure you of efficient and prompt service on your requests in State Fund cases, conforming to the photostatic copy of Mr. Stirrat's letter herewith. We also hope to merit your confidence to the extent that you will refer to us your private x-ray and clinical laboratory examinations.

Very truly yours,

WILSHIRE MEDICAL LABORATORIES,
(Signed) MAC C. SANDLER,
By Mac C. Sandler, M. T.,
Executive Director.

(Signed) F. ALFRED BLATZ,
By F. Alfred Blatz,
Public Relations Consultant.

M.S./ebg

* * *

(Copy: Letter No. 2)

(COPY)

WILSHIRE MEDICAL LABORATORIES
2016 Wilshire Boulevard, Los Angeles, California
Telephone DRexel 1235

September 27, 1941.

Dear Doctor:

It is our understanding that you are always interested in current news and up to the minute developments in modern medicine and important factors in connection therewith.

We therefore feel that you will be interested in the enclosed photostatic copy of a letter recently received by us.

The State Compensation Insurance Fund is thoroughly convinced of the quality of the Clinical and X-Ray procedures developed in this Laboratory, Doctor, and it is our earnest desire that you will share that confidence with them whenever you require professional laboratory assistance.

We shall welcome each opportunity to serve you and assure you that every effort will be made to merit the confidence you place in us.

Very truly yours,

WILSHIRE MEDICAL LABORATORIES,
(Signed) MAC C. SANDLER,
By Mac C. Sandler, M. T.,
Executive Director.

(Signed) F. ALFRED BLATZ,
By F. Alfred Blatz,
Public Relations Consultant.

Encl. s.
MCS/fg

(Copy: Letter No. 3)

(COPY OF PHOTOSTAT)

CULBERT L. OLSON, GOVERNOR

STATE COMPENSATION INSURANCE FUND

Executive Offices San Francisco

John C. Stirrat, Manager — L. I. Newman, M. D., Medical Director
J. J. Gallagher, Secretary — Donald Gallagher, Counsel
H. C. Miller, Comptroller

(SEAL)

Los Angeles, Oakland, Sacramento, Fresno, San Diego, Stockton, San Jose, Long Beach, Santa Barbara
450 McAllister Street, San Francisco

In Reply Please Mention

August 22, 1941.

Wilshire Medical Laboratories
2016 Wilshire Boulevard
Los Angeles, California

Gentlemen:

The qualifications and abilities of your personnel have been brought to my attention. Dr. Leighton Cornman, your Medical Director and Roentgenologist, has an exceptionally fine and valuable background in his specialty. The publications of which L. M. Hussey, Ph. D., your Technical Director, is the author, bespeak for his great ability as a biochemist and bacteriologist. With Dr. I. Singerman in charge of Electrocardiogram delineation together with the balance of its able staff, the Wilshire Medical Laboratories are thoroughly competent and well qualified to handle any x-ray and clinical laboratory work whatsoever.

The State Compensation Insurance Fund, as a matter of policy, has not directed where the physicians and surgeons to whom it has occasion to refer medical work should refer such x-ray and clinical laboratory work which may be required on its cases and which such doctors may not be equipped to handle personally. However, it certainly would gratify and please me very much if each of such doctors would refer such x-ray and clinical laboratory work as may be required on State Fund cases, which they are unable to perform personally, to the Wilshire Medical Laboratories.

You are at liberty to quote me concerning this expression of my confidence in the work performed by your laboratories.

Very truly yours,

(Signed) JOHN C. STIRRAT,
Manager.

JCS:LH

Created by the State of California to furnish protection to Employers at the lowest possible cost and to guarantee to their Employees all the benefits to which they are entitled.

C. M. A. ACTIVITIES: POSTGRADUATE; ANNUAL SESSION; PUBLIC HEALTH EXHIBITS AT COUNTY FAIRS

Postgraduate Conferences and Refresher Courses.—Any activity, if it has not reached its fullest capacity for service, is worthy of repeated mention. That is why the work of the California Medical Association Committee on Postgraduate Activities is so often called to the attention of component county societies. If the California Medical Association seems to have been laggard in this work, it is proper to state that it is only having the experience of many other state medical societies. Physicians everywhere acknowledge the importance of keeping in touch with changing procedures and newer methods in diagnosis and treatment. Their noncoöperation in regard to refresher and after-graduation courses is not due, therefore, to any lack of recognition of the need of such work. The explanation is to be found, rather, in the demands of private practice and patients, that nothing shall interfere with the attendance of the physician if he be within call at a time when indisposition or illness manifests itself.

A limited number of physicians have learned, however, that attendance at follow-up and post- or after-graduation courses is the better policy in the long run, because whatever makes for a better quality of service, also, in time, promotes a larger and a more lucrative clientele. However, the alert physician, no matter what his year or place of graduation, will always, for his own sake, seek to add to his store of professional knowledge so that he may be able, in turn, to give far more efficient service. By so doing, the outlook of a youthful mind is best promoted.

Wherefore, if your county society has not yet appointed a postgraduate committee, you are again urged to sponsor such a movement. The California Medical Association Postgraduate Committee, through the Association Secretary, will be happy to send supplementary information to local committees, and to be of all possible aid in giving publicity to refresher and other programs.

* * *

Annual Session: Del Monte, May 4-7, 1942.—Time flies, and next year's annual session will be at hand, almost before most of us are aware. Members who are in position to submit papers for the program are again reminded to promptly communicate with the proper Section Secretary.* Physicians who are in position, also, to present scientific exhibits or medical films, are requested to write to the Association Secretary at 450 Sutter, San Francisco, for further information.

* * *

Public Health Exhibits at County Fairs.—In spite of a late start, the effort to present public health exhibits at county fairs was carried through during this first year's endeavor with more success than had been anticipated. Hence, it is gratifying to know that the members of local committees, under whose auspices some sixteen exhibits were presented, were all favorably impressed with the value of this important publicity medium. In order to make possible a presentation of this activity on a much larger scale at next year's fairs, every county society is urged to promptly appoint its committees; for the California Medical Association Committee on Public Health Education will greatly appreciate such coöperation.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 255.

* Names and addresses of section officers appear on advertising page 6 of CALIFORNIA AND WESTERN MEDICINE.

EDITORIAL COMMENT†

VIRUS AGGLUTINATION

Successful applications of the new technique of specific agglutination of virus-coated bacteria are currently reported by Roberts and Jones [1] of the Department of Bacteriology, St. Louis University. Data thus far published by the St. Louis investigators suggest that the new technique may be of wide clinical application and may necessitate numerous revisions of basic concepts in many fields of practical diagnosis and therapy.

About fifteen years ago it was shown by Freund,[2] and has been subsequently confirmed by other investigators,[3] that if a soluble protein is adsorbed on the surfaces of small particles, the coated particles are readily agglutinated with the antiserums of animals immunized against this protein. Collodion particles were used by the earlier investigators. Jones,[3] however, found that certain nonpathogenic bacteria are more readily coated by alien proteins, heat-killed B. prodigiosus, for example, being successfully coated with horse or beef proteins by mere incubation in the presence of horse or beef serum. After thorough washing with saline solution, the exposed bacterial cells can be agglutinated by minute traces of homologous rabbit precipitins.

Quantitative comparisons showed that the agglutination test is at least one hundred times more delicate than the routine precipitin test with the same protein. In a rabbit injected with a single subcutaneous dose of 0.1 cubic centimeter of horse serum per kilogram of body weight, for example, the routine precipitin test shows no trace of specific antibody formation till the fourth day. Using a suspension of horse-protein coated B. prodigiosus as the diagnostic agent, however, specific antibody formation may be demonstrable as early as twenty-four hours, the titer rising to a maximum by the fourth day. After this, there is a precipitous fall in titer, antibodies, however, being demonstrable for many weeks after their apparent complete disappearance as shown by the conventional precipitin reaction. Applying this new diagnostic reagent to human beings who had received antigenic foreign proteins, Roberts and Jones found that in man also antibodies can be detected much earlier than currently assumed and that they present in significant amounts much longer than now believed.

Since the new agglutination technique is capable of detecting antibodies in quantities too small to be revealed by routine methods, there is a suggested necessity of an experimental restudy of many fields of clinical immunology. Applying the new technique to a study of St. Louis type encephalitis, for example, Roberts and Jones found B. prodigiosus could be effectively coated with the virus by incubating the heat-killed microörganisms in a saline emulsion of infected mouse brain. That the virus was actually adsorbed on the bacteria was indicated by the observation that after repeated washings with saline solution, such coated cells will reproduce typical encephalitis upon intranasal implantation in mice.

Suspensions of encephalitis-coated bacteria were used as diagnostic antigens. Rabbits repeatedly injected with encephalitis brain suspensions yielded antisera which agglutinated the virus-coated bacteria in dilutions as high as 1:512, control tests with the serum of normal rabbits and of rabbits immunized against normal mouse brain, giving negative results. In convalescent human beings the same specific agglutination reaction occurred in dilutions as high as 1:128. Eighty per cent of all supposedly normal individuals gave positive reaction usually in dilutions higher than 1:8. In most, but not all, instances the agglutinin titer is correlated with the viricidal index. Experiments are now under way to apply the same technique to poliomyelitis and to other conditions in which low titer antibodies conceivably play an important clinical rôle. Applications to allergy, to the toxemia of pregnancy, and to malignant diseases will be awaited with interest.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

MENSTRUAL TOXIN

Demonstration of a highly toxic euglobulin in menstrual discharge is an interesting confirmation of a popular medical belief.

In order to study the physiological properties of the menstrual flow, Smith and Smith,[1] of the Fearing Research Laboratory, Brookline, Massachusetts, collected, by means of soft rubber cups, thirty-seven specimens of menstrual discharge from normal parous women. Pooled samples from each woman were placed in the refrigerator, control samples of citrated venous blood being collected from the same individuals.

The Brookline gynecologists found that menstrual discharge is lethally toxic for normal, mature female rats, if injected subcutaneously in 0.1 to 1.0 cubic centimeter doses. Toxicity was greatest during the preëstrus period. Within 24 hours after the first injection, the animals were usually "hunched up," water intake was increased, the nose and inner canthi of the eyes were encrusted with blood, and a firm, wide area of edema had developed about the site of the injection. Death usually resulted within 48 hours. At autopsy widespread edema, with capillary hemorrhages, were noted in the lungs

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Roberts, E. C., and Jones, L. R.: Proc. Soc. Exper. Biol. and Med., 47:11, 74 (May), 1941.

2 Freund, Jules: Amer. Rev. Tbc., 12:124, 1925.

3 Mudd, S.: et al.: Jour. Exper. Med., 52:313, 1930. Jones, F. S.: Jour. Exper. Med., 46:303, 1927; 48:183, 1928. Delues, Edna: Jour. Infect. Dis., 60:55, 1937.

1 Smith, O. W., and Smith, G. V. S.: Proc. Soc. Exp. Biol. and Med., 44:100 (May), 1940.

and other internal organs, with occasional blood in the urinary bladder. The most constant lesion was in the adrenal cortex. In rats that died early, adrenal hemorrhages might be the only demonstrable lesion. With later deaths, widespread adrenal necrosis was microscopically demonstrable.

If the injections were started at the beginning of the post-estrus period, the animals were more likely to survive, and to develop a relative immunity. Male rats and spayed females are highly refractory. A simultaneous injection of estrogen increases the toxicity in rats with intact ovaries; but it has no adjuvant toxic action in spayed female rats. From this the Brookline investigators conclude that "susceptibility to the menstrual toxin depends upon the presence of the ovaries," a conclusion confirmed by simultaneous injection of ovarian emulsions into spayed females which renders them susceptible. Large amounts of progesterone completely protect female rats from this toxin. From this, too, the Smiths conclude that the corpus luteum functions as an antitoxic endocrine. Chemical analyses show that the toxin is nondialysable, and found in greatest concentration in the euglobulin fraction of the menstrual discharge.

Mature female rabbits are extremely susceptible to this toxin, a single subcutaneous injection of 1 cubic centimeter often resulting in death within 48 hours. Repeated sublethal doses will immunize rabbits against the euglobulin, the resulting antiserum protecting female rats against multilethal doses of menstrual discharge.

Bacteriological examinations and control tests, with purposefully contaminated venous blood, rule out the probability that the menstrual toxin is a product of bacterial action. The toxin is apparently a specific endometrial product, which possibly functions as a hitherto unrecognized hormonal regulator of the normal sexual cycle.

The fact that the menstrual toxin is antigenic, and that its maximum toxic effects are manifest only under certain hormonal conditions, render the alleged toxic menstrual euglobulin a very promising instrument of immuno-endocrinologic research. A considerable amount of Smith's alleged effects, however, cannot be explained by our present knowledge of endocrinology and, therefore, should not be accepted without confirmation.

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Of the various causes of accidental death, in the United States, motor vehicles lead; indeed, in 1939 they were responsible for 35 per cent of all such deaths, killing a total of 32,600 persons; in fact, a person died every 16 minutes throughout the year from automobile accidents. The number of deaths was two and one-half times those caused by syphilis, equal to those caused by diabetes, and one-half of those caused by tuberculosis. More children were killed by traffic accidents in 1939 than died from diptheria, measles, scarlet fever, and whooping cough combined. Besides the fatalities, 1,150,000 other persons were injured. Of every five who died in traffic accidents, two were pedestrians.

ORIGINAL ARTICLES

ADMINISTRATIVE PSYCHIATRY*

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IT is my purpose today to present a brief discussion of administrative psychiatry, not in general terms, but in the more concrete terms of policies and operations of the State Department of Institutions, which are now in effect or expected to be put in effect in the near future.

In the field of psychiatry, science has outrun its applications; and I have conceived the main task of the Department to be that of introducing, in our practice, all measures and procedures that would be justified by the knowledge in our field which is well established but pigeonholed in scientific archives.

Some of these measures and procedures are new for California; but most of them had already been introduced, to some extent, during previous administrations, and we have been seeking merely to encourage their more systematic and more complete development.

OVERCROWDING IN MENTAL HOSPITALS

The mental hospitals of our State, like those of all other states in the Union, have been for many decades, and still are, in a condition of overcrowding to an extent averaging between 15 and 30 per cent beyond their capacity. During the past ten years we have been spending an average of $3,200,000 per biennium for major construction; but, at the same time, the net increase of the population of our mental hospitals has been at the rate of 840 patients per year, and for this reason the construction of new hospitals, or of additions to existing hospitals, has had no appreciable effect on the overcrowding.

The principal measures that we have planned for coping with this problem are: first, provision of facilities for prevention, early diagnosis, and timely treatment of mental disorders, with a view to stemming the flood of commitments of patients in advanced and, therefore, more chronic stages of their illness, who become, for the most part, permanent inmates of our institutions; and, second, extension of our parole system and other devices for extramural care of chronic, but inoffensive mental patients.

In other words, measures for the relief of overcrowding now consist not only of construction of additions to our institutions, but also of diminishing our intake of patients and increasing their outgo.

THE LANGLEY PORTER CLINIC

Appropriations have been obtained from the Legislature for the establishment of an acute neuropsychiatric unit on the campus of the Medical

* From the office of the director of the Department of Institutions, State of California.
Read before the Second General Meeting at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

Center of the University of California in San Francisco. This new institution, which is to be known as The Langley Porter Clinic, will be a 100-bed hospital and expected to be ready to open for reception of patients on or about January 1, 1942.

Provision has been made in the new building for a large outpatient department, which should create opportunities for preventive work.

Provision has also been made for early diagnosis and prompt institution of indicated treatment, such as fever therapy, insulin-shock therapy, chemical and electrical convulsive therapies, brain surgery for tumors or focal epilepsy, and the like.

A sort of partnership has been worked out between the Department of Institutions and the University of California, whereby much-needed training of personnel will be furnished at the new institution: training of medical students, graduate training of physicians, and special training for work in the neuropsychiatric field of nurses, social workers, and clinical psychologists.

Last, not least, provision is to be made for neuropsychiatric research. The partnership of the Department of Institutions with the University of California would seem an ideal one for the promotion of such research. The Department of Institutions has, in its hospitals, a vast amount of clinical and pathologic material, in which all neuropsychiatric research problems are rooted, and with the aid of which the necessary researches would become possible. The University of California will make available, for purposes of such researches, all necessary scientific personnel, facilities, and equipment.

ACTIVE THERAPY OF THE PSYCHOSES

Pending the establishment of The Langley Porter Clinic, the provision of active therapy of the psychoses in our mental hospitals has not been neglected. Such provision will, indeed, always be necessary for committed patients.

Attempts to introduce insulin-shock therapy in state hospitals had been made in a number of other states, and in California before the present administration assumed office. This is by no means a simple matter, and this type of therapy had been only partly successful in most institutions.

We were fortunate in being able to obtain, through the courtesy of the University of California, the services of Dr. Jacob P. Frostig, who, almost from the beginning, had participated in the original researches whereby insulin-shock therapy was developed and standardized. With him as a special instructor, this therapy was introduced at Camarillo State Hospital in the summer of 1939, for cases of schizophrenia under one year's duration, in the southern part of the State, and about a year later in Stockton State Hospital, for the northern part of the State.

There has been, both in Camarillo and in Stockton, an accumulation of a waiting list of patients requiring this treatment. Moreover, it seems desirable to extend the benefits of this treatment to cases of up to two years' duration. Therefore, at this time provision is being made for the use of insulin-shock therapy in Patton State Hospital, to be followed later by the introduction of this treatment elsewhere, probably in Agnews State Hospital.

Convulsive therapy, with the aid of metrazol has long been in use in our mental hospitals, having been found of special value in agitated depressions and in certain catatonic states.

As all know, metrazol therapy is fraught with some serious disadvantages, and seems to be destined to be replaced by convulsive therapy induced by means of electricity.

Many details of technique of electro-shock therapy are somewhat uncertain, and we have under way negotiations with the California Institute of Technology at Pasadena for the necessary research work whereby electro-shock therapy will be applied with precision, and with full control of every detail of the procedure.

In these ways steady progress is being made along the line of raising the recovery rates and shortening the duration of acute and subacute cases of schizophrenia, and of involutional melancholia and other types of agitated depression. In these ways, too, many chronic patients with catatonic stupor and catatonic excitement improve sufficiently to become better behaved and easier to care for, helpful in the institutions, and eventually, suitable for release on industrial parole or for family care.

EXTRAMURAL CARE OF MENTAL PATIENTS

For many years there has been a trend in the Department of Institutions toward a more liberal parole policy. With the consent of the Governor and the Legislature, in the early part of 1939 appropriations were made available for the establishment of a division of extramural care, employing many additional social workers in our seven mental hospitals. There is now a Supervisor of Extramural Care, whose headquarters are in the Department's office in Sacramento.

The number of patients on parole from the seven mental hospitals has been increased from 2,993, on December 31, 1938, to 4,880, on March 31, 1941. Patients in extramural care are classified in three main groups: those on parole at home; those on industrial parole; and those in family care.

With the aid of old-age assistance, and with the aid of further special financing to be approved by the Legislature, we expect, in the course of the next biennium, to increase the number of patients from mental hospitals in family care by at least 2,000, thus raising the total number of patients in extramural care to about 7,000.

Although these measures have not yet been completely developed, there has been already a partial checking of the heretofore steady increase of the population of our mental hospitals. Thus, during the ten years preceding the present administration, the increase of the population of our mental hospitals occurred at the average rate of 840 per year. During the calendar year 1940, that increase was by but 143.

FEVER THERAPY FOR PREPARETIC STAGES OF NEUROSYPHILIS

For many years cases of general paresis constituted about 7 per cent of the admissions to our mental hospitals. Most of these cases reached us in advanced stages of the disease, with established mental deterioration attributable, no doubt, to extensive brain tissue destruction that had already taken place. Fever therapy applied to these cases resulted in degrees of recoveries justifying release from the hospitals in but 25 or 30 per cent of the cases. The problem is obviously one of applying fever therapy in preparetic stages of neurosyphilis.

Accordingly, our seven mental hospitals have been made available for the admission of patients with neurosyphilis who are not yet insane, but who would be received on their voluntary application and treated by means of malarial inoculation.

The task of inducing patients of this group to accept hospitalization in our institutions for this purpose has been assigned to the division of extramural care. At the present time, about one out of three of the patients with neurosyphilis, admitted to our hospitals, is admitted on voluntary application.

It has been estimated that about 2,000 persons are registered in the records of the State Department of Health who have neurosyphilis, and in whom malarial inoculation might be indicated. This is the reservoir of patients from which our cases of general paresis are recruited. The more of them we can bring into our hospitals for malarial inoculation, the fewer cases of paresis will develop. The progress thus far made in connection with this matter encourages us to look forward to a dwindling of the numbers of cases of general paresis until an almost negligible residue will remain.

TUBERCULOSIS IN MENTAL PATIENTS

It is a matter of common observation that tubercular morbidity and mortality among inmates of mental hospitals is much higher than in corresponding age-groups of the unselected population. This is due partly to the overcrowding prevailing in all such hospitals, and partly to the great difficulty that is experienced in enforcing, among mental patients, the simple habits of personal hygiene, such as refraining from careless sneezing, coughing, and expectoration; cleansing of mouth and nasal passages; and the cleanliness of hands.

Thus a special hazard of tuberculosis exists for all inmates of mental hospitals and for employees as well.

In order to minimize this hazard, steps were taken, without delay, for the segregation of actively tubercular patients in special buildings in Patton State Hospital, for the southern part of the State, and in Napa State Hospital, for the northern part.

Appropriations were secured from the Legislature for the construction of special buildings for tubercular patients in these two institutions. Such buildings have already been completed and are now housing tubercular patients at Patton; and contracts for the construction of similar buildings have been awarded at Napa.

In these ways, not only the epidemiologic problem of tuberculosis in our mental hospitals has been solved, but also greatly improved facilities for the early diagnosis, and proper medical and surgical treatment of cases of tuberculosis, have been provided.

IMPROVED DIET RATIONS FOR INSTITUTION INMATES

The Department of Institutions has, for many years, made careful provision for adequate diet rations for the inmates in the institutions in its jurisdiction. Ten or fifteen years ago the main emphasis in this connection was laid on caloric requirements. The great recent advances in our knowledge of vitamins has necessitated some revisions in our rations. The most difficult phase of the problem seemed to be how to provide, without prohibitive cost, an adequate daily supply of B-complex vitamins.

The problem was solved for us by a committee of the National Research Council in Washington, which has formulated specifications for an "enriched" flour, to be had from the large milling companies at a slight increase of cost over ordinary types of flour. We are now introducing these specifications in our orders for flour to be supplied to us by the purchasing bureau of the Department of Finance.

NEW INSTITUTION FOR DEFECTIVE AND PSYCHOPATHIC DELINQUENTS

There are, in the jurisdiction of the Department of Institutions, three correctional schools and two institutions for the feebleminded and epileptic. The work in both types of institutions is being greatly hampered by the presence in them of defective and psychopathic delinquents.

It has been the experience, not only of the California correctional schools, but also of similar institutions in other states, that permanently successful rehabilitations of inmates have been attained in but a minority of the cases dealt with.

There is a great deal of new evidence, some of which has been yielded by recent studies of delinquency and criminality in twins, indicating that there is an organic basis, in the form of residuals of cerebral birth trauma, postnatal cerebral trauma, and acute infections complicated with cerebral involvement, underlying most instances of defective and psychopathic delinquency. This fact would account largely for the poor prognosis of such cases.

The presence of defective and psychopathic delinquents in a correctional school has the effect, also, of impairing the prognosis of a good many other inmates of such institutions, by a process comparable to contagion.

Hence, there has been under way in California, for at least fifteen years, a more or less active movement seeking the establishment of a special institution for the care of defective and psychopathic delinquents. This would simplify the work of the correctional schools and raise their rehabilitation rates to at least double their present percentages. At the same time, by the timely and permanent segregation of defective and psycho-

pathic delinquents, the development of criminal careers would be prevented on a scale that would hardly be possible by the application of any other known measure.

SUMMARY

To summarize as briefly as possible: The tasks of administrative psychiatry, as we are endeavoring to perform them in the Department of Institutions, are those of preventing mental disorders and delinquency; raising the recovery rate of mental disorders by means of active therapy of the psychoses; raising the percentages of successful rehabilitations of juvenile delinquents; and providing, in extramural environments, a normal family life for many selected chronic patients from our mental hospitals.

California State Department of Institutions.

TUMORS OF THE SMALL INTESTINE*

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AND
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NUMEROUS individual case reports have been made of tumors of the small intestine, but due to their rarity there are few groups large enough to obtain a satisfactory statistical study. King, in 1917, reviewed the literature and was able to find fifty cases of benign tumors of the small intestine. In 1929, Rankin and Mayo reported fifty-five cases of carcinoma of the small intestine which had been seen at the Mayo Clinic. During the same period, 4,597 carcinomas of the rectum and colon were found, and 4,335 cases of carcinoma of the stomach were observed. In 1933, Rankin and Newell were able to find only thirty-five cases of benign tumors of the small intestine. Raiford reviewed the literature in 1932 and found 337 tumors which could be considered as authentic, noninflammatory, primary tumors. He presented a series of eight-eight cases which represented a study of 11,500 autopsies and 45,000 surgical specimens. Fifty of these tumors were benign and thirty-eight malignant.

SOURCE OF MATERIAL

This group of forty-five cases of tumors of the small intestine represents the tumors recognized in 25,621 autopsies from 1918 to 1941, and those recognized in general surgery from 1913 to 1941 at the Los Angeles County General Hospital, together with the surgery and autopsy records covering 28,390 admissions from 1929 to 1941 at the Santa Fe Coast Lines Hospital. All tumors in this group were primary lesions; no metastatic nor inflammatory lesions were included.

It is impossible to more than theorize in explaining the infrequency of tumors of the small intestine. The fact that the small intestine develops, for the most part, in the latter months of fetal life makes it reasonable to assume that there is less chance of a fetal rest's remaining. Cohnheim's theory definitely explains how certain tumors develop as the result of these rests. Investigators have attempted to explain the infrequency of small bowel tumors on the basis of the rapidity with which the intestinal contents pass through the small intestine in contrast to the relative stasis which occurs in the stomach and colon. The assumption is made that stasis produces irritation and that irritation predisposes to new growth.

TABLE 1.—*Type of Tumors Found*

Type	Number	Per Cent
Benign		
Aberrant pancreatic rest	1	2.2
Adenoma	3	6.6
Carcinoid	2	4.4
Fibroma	1	2.2
Fibromyoma	9	19.9
Lipoma	2	4.4
Hemangioma	1	2.2
Malignant		
Adenocarcinoma	17	37.7
Fibrosarcoma	5	11.1
Lymphosarcoma	2	4.4
Melanoma	2	4.4
TOTAL	45	100.0

Table 1 illustrates the type of tumors found in this series. Twenty-six are malignant and nineteen are benign. Adenocarcinoma is the most frequently encountered malignant tumor. Fibrosarcoma is next. Lymphosarcoma and malignant melanoma are less than half as frequent as fibrosarcoma.

Of the benign tumors, fibromyomas are found in nine cases. Three are adenomas. Two are lipomas and two carcinoids. There is one aberrant pancreatic rest, one fibroma, and one hemangioma.

Table 2 illustrates the age distribution of the benign and malignant tumors. There seems to be very little relationship between age and the occurrence of benign tumors in the small intestine. Malignant tumors in this series occur most frequently between the ages of fifty and seventy.

TABLE 2.—*Age Distribution of Tumors Found*

Age	Benign		Malignant	
	Number	Per Cent	Number	Per Cent
0- 9	3	6.6	0	0.0
10-19	1	2.2	1	2.2
20-29	0	0.0	2	4.4
30-39	4	8.8	3	6.6
40-49	3	6.6	3	6.6
50-59	4	8.8	6	13.3
60-69	1	2.2	5	11.1
70-79	2	4.4	4	8.8
80-	1	2.2	2	4.4
TOTAL	19	41.8	26	57.4

* Read before the Section on General Surgery at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

BENIGN TUMORS

An aberrant pancreatic rest was found in only one case. Although most commonly seen in the upper end of the small intestine, where they usually do not cause symptoms, this accessory pancreatic tissue was found at autopsy in the terminal ileum and caused an intussusception. Warthin's theory is that these rests arise from the lateral buds of the developing pancreatic duct as they enter the intestinal wall. As growth takes place in the gut in the linear direction, these rests may be carried along in either direction. Simpson, in 1927, collected a large series of these tumors and observed that there was a close relationship between the ventral pancreatic duct and the primitive yolk stalk. He theorized that small islands of pancreatic tissue might become implanted in the gut at this point.

Three benign adenomas were found in this series. These tumors are usually asymptomatic unless they reach a size sufficient to cause obstructive symptoms. They may be single or multiple and vary in size from several millimeters to several centimeters in diameter. Saint presented Hauser and Bordenauer's theory of primary epithelial change as being a possible explanation of their etiology. Saint's own theory was that a thickening takes place in the mucosa, followed by a thickening in the submucosa. The action of the intestinal contents passing along the intestinal tract causes a pedicle to form. This is followed by a glandular proliferation. Saint points out that these steps are most probably due to inflammation. He believes that these tumors are most frequently found in the areas where inflammatory reaction is commonly found.

In two of this series, carcinoids were found. Several small submucous plaques, about one centimeter in diameter, in the region of the jejuno-iliac junction, were seen in one case; in the other case there were two small submucous plaques, about three millimeters in diameter, found in the terminal ileum. Both were found, incidentally, at autopsy and had caused no clinical symptoms.

Carcinoid tumors sometimes are called argentaffin tumors because of the presence of numerous silver-staining granules as originally described by Gosset and Masson in 1914. Grossly, they usually look like submucous plaques although they may have a sessile base. Occasionally a pedunculated tumor may be found. Metastases have been reported, but rarely occur in true carcinoids. Various theories have been advanced as to their etiology. They are thought by some to represent pancreatic rests; by others to be similar to basal cell carcinoma; and by still others to possibly be related to the super-renal or other chromaffin tissue. No one theory has been proved as explaining the etiology of carcinoids.

One fibroma was found in this series. This type of tumor, histologically, is similar to connective tissue. The fibroma in this series occurred in the ileum of a boy thirteen years old. Fibromas are commonly found in the same location in older individuals. Symptoms usually are caused on a purely mechanical basis.

One hemangioma was noted in this series. The patient from whom this specimen was removed had had two previous abdominal operations in an attempt to determine the cause of profuse intestinal hemorrhages. The tumor involved 60 centimeters of jejunum. The dilated blood spaces usually occur in the submucous layers of the bowel. Intestinal bleeding is a common symptom of these tumors.

Of the nine cases of fibromyomas found in this series, eight occurred in the jejunum and one in the ileum. In six cases the symptoms caused by the tumor were those of intestinal obstruction. In two cases intestinal bleeding occurred in addition to cramp-like abdominal pain. In one case a fibromyoma was an incidental finding. It is quite probable that these tumors arise from one of the muscular coats of the adjacent bowel wall.

There were two lipomas found in this series; each was located in the ileum. In one case the lipoma produced an intussusception; in the other case, partial intestinal obstruction. These tumors cause symptoms almost entirely by mechanical complications. Lipomas may occur within the lumen of the bowel, as was found in these cases, or they may be found on the outer surface of the intestine. Odelberg found that 25 per cent of all intestinal lipomas are found in the small intestine.

MALIGNANT TUMORS

There were seventeen adenocarcinomas in this series which included lesions of the ampulla of Vater. Five tumors were found in the duodenum; all were small, varying in size from three centimeters to four millimeters in diameter. There was evidence of metastatic spread in all cases. All the patients died; one following a palliative cholecystduodenostomy, the remainder without surgical treatment. Seven carcinomas were found which were primary in the ampulla of Vater. The correct preoperative diagnosis was made in three cases. Other diagnoses were common-duct stone, carcinoma of the head of the pancreas, carcinoma of the stomach. In one case the lesion was found, incidentally, at autopsy. It is not surprising that the correct diagnosis was made in these three cases, inasmuch as localizing signs and symptoms due to obstruction of the ampulla of Vater are so striking. All seven persons died.

Three cases of carcinoma of the jejunum were found. One of the cases had a low-grade papillary adenocarcinoma in a young man twenty-four years old. This patient had survived five years without clinical evidence of recurrence. Two adenocarcinomas were found in the ileum. One case had double primary tumors, eight and eighteen inches, respectively, from the ileocecal valve. Both of these patients died.

Five fibrosarcomas were found in this series. Three were in the jejunum, and two were in the ileum. Many observers believe that sarcomas offer a better prognosis than do carcinomas. This unqualified statement cannot be evaluated. All but one case developed metastases; one patient died as the result of perforation of the tumor in the terminal ileum. No metastases were found in this case at autopsy.

Two cases of lymphosarcoma were found in this series. In a series of twenty-one lymphosarcomas of the small intestine, Raiford found all in the terminal 100 centimeters of the ileum, with one exception, the location of which was the second portion of the duodenum. Raiford's cases were found chiefly in young individuals. One case in this series occurred in the duodenum of a young man twenty-nine years old, the other in the jejunum of a boy seventeen years old.

Two cases of malignant melanoma of the jejunum were found. These are rarely found as primary tumors of the small intestine. They are very malignant, metastasizing early, and many times by way of the blood stream.

Of the forty-five cases presented, eleven either entered the hospital moribund and no complete diagnosis could be established, or a tumor of the small bowel was an incidental finding. Eighteen cases entered as surgical emergencies. Extensive roentgenologic examination could not be made. In none of these cases was a small bowel tumor suspected. Sixteen cases entered with ample time for study. Of these a correct diagnosis was made in four. Three cases were carcinoma of the ampulla of Vater, one was hemangioma of the jejunum. Roentgenologic examination, with motor meal study together with intestinal intubation, seem to offer the greatest hope of improving the number of correct diagnoses in this latter group of cases.

SUMMARY AND CONCLUSION

A series of forty-five cases of tumors of the small intestine is presented. The various types of tumors are discussed as to their location, type, and age incidence. Only one-third of the total number of cases in this series came under observation soon enough for adequate preoperative study. Early roentgenologic examination, with motor meal studies and intestinal intubation, offers considerable hope of increasing the number of cases correctly diagnosed.

1037 Pacific Mutual Building.

ESTROGENS: THEIR USE IN PEDIATRICS*

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THIS discussion will consider why, when, and how to use estrogens in order to keep in the zone of safety while using them. The paper will not consider the use of progesterone or pituitary factors.

Estrogen hormone preparations can be prepared by extraction from animal ovaries or by synthesis. By the method of natural extraction from tissues, sufficient hormone for clinical use would be impossible to prepare. Fortunately estrogens can be synthesized in sufficient quantities; these products are very potent, their costs are becoming sufficiently low, so that they are available and practical for clinical use. Myriads of trade names are now on the market. A product should be of reliable potency before being used.

Estrogens are now available for use by mouth, by vagina, by inunction, by implant subcutaneously, and by injection. One can avoid needling a patient and can secure a good response, which thus makes estrogen usage in pediatrics very attractive. As a matter of fact, I would prefer not to inject in certain problems, but to use estrogens by other routes since this would more likely insure continued therapy with better results and less distress for all concerned.

The hormone, called alpha estradiol, elaborated by follicles of the ovary, is only one of several estrogens. Others are stilbestrol, triphenylethylene, etc. As stated, the estrogens can also be synthesized. The alpha isomers being more active than the beta, and the organic esters being more slowly absorbed and excreted, estradiol is most often used in these forms. Estrogens occur as three general chemical types—estradiol, estrone, and estriol. Because of their varying chemical structure they are absorbable with very little alteration or attenuation by different body tissues, and thus can be administered to the patient by different routes. The intestinal mucosa will absorb estriol and estradiol; the vaginal mucosa mainly absorbs estrone; the skin, subcutaneous and muscle tissues, estrone and estradiol. Obviously effective oral and vaginal application are particularly helpful in pediatrics, since injection is not the only available way. Indeed, Dr. Evelyn Anderson of the University of California has recently announced that she can induce absorption through the oral mucosa, an impossibility hitherto. Doctor Anderson suspends estrogen in propylene glycol, and even in drop dosage under the tongue effects are very rapid. Estrogens can also be given, if indicated, into vein or peritoneal cavity with rapid and pronounced effect.

Estrogens in ordinary therapeutic doses do not stimulate the ovary, but are only substitutive, as is insulin. Primarily, estrogens activate the secondary sex characteristics, and their development is of a more permanent nature. However, in heavy doses estrogens may have a stimulating effect on the pituitary body, which gland may then cause a permanent ovarian follicular activity and thus menstruation. Excessive doses of estrogen depress the pituitary.

INDICATIONS

In pediatrics the usual usages for estrogens are in the problems of adolescent menstruation and, occasionally, mastopathies and vulvovaginitis. There are other uses—unusual ones—which will be mentioned.

The dosage is variable and individual. In general, the desideratum is to stimulate the normal cyclic variation of estrogen production. Often the dose is much higher initially to induce change, and lower, as maintenance, after the changes are effected. Occasionally, as in vulvovaginitis, it is desirable to give rest periods of seven to ten days after each three to four weeks of treatment. Thus cumulative effects and possible resistance to the estrogen are avoided. The induction of precocious puberty when undesirable can be prevented by avoiding excessive single doses. In ordinary thera-

* From the Department of Pediatrics, University of California Medical School, San Francisco.
Read before the Section on Pediatrics at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

TABLE 1.—*Lists a Few of the Commonly Known Estrogens Classified Under Their Particular Chemical Group.* A list of costs was included in the original table, but because of the great variability and to save space, this was deleted. Note the route of administration varies with the chemical structure.

Preparation Trade Name and Company	*Source of Material*	*Administration*			
		Injection	Oral	Vaginal	Percutaneous
Estrone (Ketohydroxyestrin)	Mixed, natural, synthetic or isolated from human pregnancy urine and placenta				
Amniotin—Squibb		+	+	+	
Estrone—Lilly & Abbott		+		+	
Theelin—Parke, Davis		+		+	
Menformon, Kolpon—Roche					+
Estradiol (dihydroxyestrin)	Synthetic. From sterol, etc.				
Dimenformon—Roche			+		
Ovocylin—Schering			+	+	
Progynon-DH			+		+
Stilbestrol		+	+		
Estradiol Benzoate (dihydroxyestrin)	Synthetic. From sterols				
Ben-ovocylin—Schering		+			
Progynon-B—Schering		+			
Dimenformon benzoate—Roche		+			
Estradiol Proprionate and Diproprionate	Synthetic. From sterols				
Dimenformon diproprionate		+			
Di-Ovocylin		+			
Progynon-DP					
Estriol (trihydroxyestrin)	Synthetic. From sterols				
Theelol—Parke, Davis					
Estriol—Lilly, Abbott	Human pregnancy urine and placenta		+		
			+		
Emmenin, Ayerst	Ester of trihydroxyestrin		+		

peutic dosage this need not be feared. Likewise, malignancy need never occur. As a matter of fact, for this to occur tremendous single doses have to be frequently repeated over a long period of time; nay, it will probably never occur in a human being.

The menstrual disorders of an adolescent now merit therapy, since the present estrogens are so effective and can be given by routes easier than injection. Yet not all cases are relieved. Patients should be thoroughly examined to detect any deviations in hygiene, diet, nutrition, or any other disease. Blood counts, blood pressure and local examination of external genitalia, and particularly rectal palpation of internal genitalia, should be done. If indicated, basal rate and other endocrine laboratory procedures should be carried out. After all, relief can be given with other than endocrine therapy, thus avoiding the error of ascribing an endocrine cause to a menstrual disturbance. However, one must remember that, when indicated, a small dose of thyroid often is dramatic, and that the patient actually had a latent hypothyroidism.

Primary amenorrheas require large doses (1.0 10.0 milligrams weekly by injection), to build up the proliferative phase. The uterine hypoplasia can be helped by oral administration of 0.5 to 1.0 milligrams daily for a two-week period. A girl of fifteen or sixteen years should not be allowed to go much longer without attempting this artificial induction, especially if no secondary sex characteristics are present. Since estrogens only are being considered in this paper, little will be mentioned about pituitary gonadotropins. However, they are a logical choice, singly or with estrogens.

In secondary amenorrhea, oral treatment in small doses (0.3 to 0.5 milligrams daily) can be used at the start, but injection (for instance 2 milligrams every four days, six times each month) may be necessary. Dosage will depend on the degree of uterine infantilism.

Dysmenorrhea, if there is uterine hypoplasia, merits treatment with estrogens, 2.5 to 5.0 milligrams, injected twice weekly during the first two weeks of the intermenstruum to stimulate the normal cyclic production by the ovary, may build up the uterine muscle, resulting in more coördinated and less painful contractions. Five-tenths to one milligram daily, orally, in the first two weeks of intermenstruum, or .01 to .05 milligram daily throughout the cycle have been successful. Alternation with pituitary gonadotropins may be tried. Excessive doses of estrogens in the midcycle, to suppress ovulation, may relieve dysmenorrhea. The pain from an antiflexed uterus has been relieved by estrogens.

Menorrhagia and metrorrhagia are bothersome for young girls, often dangerous, and, as such, estrogen treatment may be tried and often may cure or alleviate. Injection of large doses or oral dosage in the last half of the cycle are the choices.

Occasionally, mastopathies require more than the usual palliation—analgesic drugs, cold packs, and support of the breast. Pain is relieved by several thousand international units injected daily just prior to menstruation or moderate dosage through the cycle. Small doses orally also can be used just before bleeding. Cystic disease and adenosis will worry mothers. One milligram, injected twice weekly for three weeks intermenstrually, is in order. The estrogens are lacking, and their use actually counteracts excess of progesterone.

The endocrine care of vulvovaginitis is now common medical knowledge since Lewis, in 1933, first used pituitary-like gonadotropins. Endocrine

therapy is the best treatment at present, and estrogens are the endocrine of choice. This disease has been more efficiently treated by local vaginal administration than by other routes. After all, it is only a local disease. Generalized effects are far less likely to occur, especially breast development from vaginal suppositories. Personally, however, I favor oral or inunction therapy over injections or vaginal suppository, because the oral or skin route is painless and prevents genital sphere fixation in the child's mind, though possibly more expensive. Estrogens are just as useful for the nonspecific cases which in this area are probably as common as the gonorrheal cases. Treatment requires about two months' time. The following doses are recommended: orally, 0.3 to 0.5 milligram daily; vaginally, 0.1 to 0.4 milligram in capsules or suppositories daily; inunctions, 0.5 to 1.0 milligram before retiring; by injection (intramuscularly), 0.5 to 1.0 milligram twice or thrice weekly. Injection is preferred by some physicians. Treatment should be suspended after three weeks for one week.

Uses other than for menstrual disorders, breasts, and vulvovaginitis include a group of diseases which are either obliterated by puberty or improved at puberty. Some diseases of this nature are laryngeal polyps, epidermolysis bullosa, trophic and nutritional disturbance of epiphyses (Legg-Perthé's and Osgood-Schlatter diseases). One should preferably treat with the gonadal hormone similar to the patient's sex. As a rule, the dosage of estrogens used for such puberty-limited diseases is very high, much higher than the usual safe therapeutic doses heretofore prescribed, and such high dosage may not be considered advisable or safe. Precocious development of secondary sex characteristics, without true maturity (menses and spermatogenesis), has occurred in most cases. Yet, faced with a bad problem early in life, such precosity may be less of an evil than certain of these puberty-limited diseases. I am thinking of a two-year-old who may require numerous anesthesias, removal of polyps, a change also of voice from polyps, possible malignancy, etc., during the next twelve years. Estrogens have been helpful, even when sprayed on polyps.

Migraine can be treated with encouraging results even orally. It does occasionally occur in children. If at all associated with ovarian dysfunction or related to the cycle rhythm, ordinary doses (0.2 milligram) can be injected three times weekly or taken daily orally. Occasionally there have been encouraging results in alopecia, impetigo, eczema, dry skin, and acne (when associated with menstrual irregularity). Others have reported favorably on atrophic rhinitis and ozena, asthma occurring around menstruation and a number of other conditions apparently unrelated to ovarian function. Finally the premature may be successfully carried along by .05 milligram daily orally or subcutaneously, lessening initial weight loss and increasing the percentage of survivors.

University of California Hospital.

CANCER OF THE PROSTATE*

A REPORT OF THIRTY-FOUR CASES SEVEN AND EIGHT YEARS AFTER TREATMENT BY TRANSURETHRAL RESECTION

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As habits acquired in youth persist throughout life, so subjects in which we become interested early in our medical careers intrigue us as we approach its close. The subject of my thesis for a master's degree in urology was cancer of the prostate, and, ever since, these cases have interested me profoundly. Once I reviewed the histories of one thousand cases of cancer of the prostate in an endeavor to ascertain what their life expectancy was at various times in the duration of the disease; how frequently and how early bone metastasis appeared, and how long these patients might be expected to survive if they were relieved of their urinary obstruction and the malignancy allowed to run its course untreated.

In 485 of these 1,000 cases, no form of treatment had been received. The average duration of the disease from first symptoms to death was a little short of three years. Obviously, then, any form of treatment, to be considered effective, should lengthen this period. It was interesting to find that when metastasis had occurred at the time of examination, two-thirds of the patients died within nine months.

More recently, James E. Kahler, in partial fulfillment of the requirements for his master's degree in pathology, made a pathologic study, as I did, a clinical one. His material consisted of 195 carcinomas of the prostate, of which seventy-two were discovered clinically and 123 at postmortem examinations. He made several original findings and confirmed others generally believed. For example, that 17.3 per cent of men over fifty may be expected to have cancer of the prostate. Surprisingly enough, he found that the greater percentage of prostatic cancer is recognizable neither clinically nor on gross examination at necropsy. In fact, fifty-four of his cases were obtained by taking additional slides from 490 prostatic glands, unselected except that the gland had been diagnosed nonmalignant, both clinically and on routine macroscopic and microscopic postmortem examination—a finding which demonstrates how far advanced this form of malignancy must be in order to be recognized clinically. Of all the cases in his series which had been diagnosed clinically, in over half, upon postmortem examination distant metastasis were present. He found that whenever the disease was discovered microscopically it could be demonstrated macroscopically in the gross specimen in only 7 per cent of the cases.

Many years ago, Scholl and I reviewed sixty-two cases of cancer of the prostate which had been discovered upon pathologic examination of sup-

* From the Department of Urology, College of Medical Evangelists.
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posedly benign prostates removed by both perineal and suprapubical operations. Interestingly enough, only three of these patients survived over five years, although the malignancy was so early as to be completely unsuspected clinically. As a result of our findings, we made, in 1921, the rather timid statement "that when the disease has advanced sufficiently to be recognized clinically, the possibility of surgical cure is diminished."

Experience and observation, during the past twenty years, have only tended to confirm this belief, and reports such as Kahler's seem to corroborate it; for he writes: "The microscopic diagnosis of prostatic carcinoma, as for ther tissues of the body, depends (among other things) on such criteria as undifferentiation of cells, loss of polarity, and invasiveness and avidity for basic dyes. There is, however, one criterion which may be peculiar to the prostate gland that supersedes all others: perineural lymphatic involvement. While extension of a carcinoma to a perineural lymphatic lying in its path is not by any means restricted to prostatic carcinoma, the abundance of sympathetic fibers within, and particularly around the prostate gland, and the apparently ideal conditions for growth of prostatic carcinoma in the lymphatic surrounding these fibers, forms a definite basis for its malignancy."

He found "localized tumors, many of which were small enough to occupy only one or two low-power microscopic fields, showed as high an incidence of perineural lymphatic involvement as large tumors involving the entire prostatic gland."

He then concludes: "It is evident, therefore, that local removal of the tumor itself . . . does not eradicate all of the tumor tissue even in the case of neoplasms of a low grade of malignancy. The demonstration of lymphatic pathways direct to the bone, rather than to regional nodes, raises the question as to whether an operative procedure could be made sufficiently extensive to hope to cure the disease."

Certainly his work must be accepted as demonstrating the rarity of ever diagnosing cancer of the prostate by any means now available sufficiently early to be able to promise even a probable cure. For the success of any method of cure must depend upon the extent to which the perineural lymphatics have been involved; and this, according to Kahler's work, bears no relationship to the size of the malignancy and is impossible of demonstration by rectal palpation.

COMMENT

Once cancer of the prostate has become diagnosable by the examining finger, the possibility of its cure is so remote that procedures which either jeopardize the life of the patient or subject him to extensive suffering, hardly seem justified.

Believing this, I feel we should try to ascertain as accurately as possible what palliative measures have to offer, and to comfort our patients with the assurance that, in this disease at least, early recognition has little, if any, effect on the outcome. Certainly, he who informs these unfortunates with cancer of the prostate that "it's too bad you didn't discover this earlier," has little foundation for his cheerless words.

In any large series of cases of malignant disease there are always a few patients who live many years. Thus, in my series of 485 untreated cases, there were four patients who lived more than three years and two of them more than ten years. Such cases are usually explained as errors in diagnosis, but when the diagnosis is based on microscopic examination of tissue this explanation hardly holds. Thus, in one of these cases, a malignant metastatic lymph node was removed ten years after the initial diagnosis of cancer of the prostate. The fallacy of attributing to any form of treatment all the favorable results obtained is thus graphically illustrated. When it is recorded that so many patients with cancer survived so many years following treatment, one should never forget that the chances are that a few of these survivors would have lived that length of time if no treatment had ever been given, while others might have been recorded among the living except for the mortality associated with the particular form of therapy employed.

It is necessary, therefore, in order to properly evaluate any form of treatment of malignancy, to keep this point constantly in mind. In this small series of thirty-four cases having transurethral resection during 1932 and 1933, we find three patients who lived over five and a half years. Two are dead, but one is still alive over seven and one-half vears after his resection. I seriously doubt that he is cured. His wife, in a letter dated January 21, 1941, writes:

"Hugh is in splendid health. Weighs about 190 pounds. Will be eighty-three in August. Takes care of a big garden, thirty hens, a cow, and a big lawn. He has just finished digging and cutting up a very large apple tree he planted fifty years ago."

In some reports on the treatment of malignancy, these three cases would appear as five-year cures or controls; a statement which is both misleading and regrettable, for in many such patients the disease is neither controlled nor cured. Some have been known to employ the same term for these surviving over three years, even when natural course of the disease is as long.

In my series of thirty-four cases there were ten patients who lived over three years after transurethral resection, although, with the possible exception of the individual who still survives, the disease was not controlled and certainly not cured in a single instance.

That these figures represent fairly accurately what may be expected from transurethral resection of cancer of the prostate is emphasized by the findings of a similar study made by Thompson and Emmett in 1938. They reviewed 107 cases and found seventeen, or 15.8 per cent, survived over four years following resection, and that ten patients, or 9.3 per cent, were still alive in the fifth and sixth year after operation. They write: "In two cases, the carcinoma was apparently confined to the central portion of the prostate gland, for repeated reëxamination has failed to demonstrate either local recurrence of metastasis; furthermore, biopsy has been done by removing numerous pieces

of tissue from the prostatic urethra in each of these cases, and careful study has failed to disclose evidence of carcinoma. The tissue removed at the original operation has been studied again and is definitely carcinomatous. It seems possible that in these two cases a real cure was accomplished by transurethral resection."

There were two other cases in my group which I think deserve emphasis. Each was also living after a lapse of three years and may still be, for all that I know, for they have been dropped from the follow-up.

Repeating a practice initiated by Drs. Thompson and Emmett in their study of the results of transurethral resection in cases of cancer of the prostate, I asked Doctor Broders to review the tissue removed at the time of resection in all cases still living after three years. In two of the twelve cases living over this period, he found the original diagnosis to be in error. The tissue that had been removed in 1933 and reported malignant was, in fact, benign. Except for this careful recheck, I might have had the pleasure of reporting five instead of three patients living over five years, and possibly that three of my resections instead of one had survived over seven years.

It seems to me quite within the realm of possibility that other reported cases of cures which one reads in the literature may be due to similar honest errors on the part of the pathologist who first examined the tissue.

We all know this was true in the first large series of radical cures of cancer of the breast reported by Halstead, which, upon review of the tissue by Bloodgood, were pronounced in a goodly minority to be benign.

Not many years ago the professor of urology of one of the largest midwestern state universities confided to me that the incidence of malignancy of the prostate in his cases of transurethral resection was in excess of 30 per cent. I suggested that he send some of the slides to Doctor Broders for confirmation and the error was corrected. It seems a well-established fact, from figures of various urological clinics, that the incidence of cancer of the prostate is between 15 and 20 per cent.

I doubt if too great an emphasis can be placed on this possible source of error in diagnosis. Certainly, I feel sure few would have questioned my honesty if I had included these two cases just referred to with the other three who survived over five years. In so doing, I could, in all honesty, have reported a 10 per cent of five-year controls of cancer of the prostate by transurethral resection, all proved by microscopic examination at the time of operation; end-results statistically the equal of any form of treatment of cancer of the prostate in unselected cases.

That transurethral resection for cancer of the prostate has unquestionably prolonged the lives of these unfortunate individuals, seems indicated beyond question of a doubt, for ten of the group outlived the average duration of the disease, measured from its first symptoms to death, in spite of the fact that, in many cases, it was already considerably advanced at the time of resection. Nine of the group survived less than a year following the operation, but none died as a result of an attempt to cure them. There was no operative mortality.

It has been believed for a considerable time that cancer of the prostate, with a few rare exceptions, originated in the posterior lobe. As this lobe is not removed by transurethral resection, some have logically argued that resection was contra-indicated when malignancy of the gland was suspected. Some have gone as far as to hold that, inasmuch as every fifth case of prostatic enlargement would prove to be malignant, that resection verged upon malpractice.

Fortunately, the investigation of Kahler, referred to earlier, showed that only in the median lobe did he never find carcinoma changes originating, and that its incidence in the posterior lobe was a little less than in the laterals. Comforting findings for those who believe palliative rather than curative surgery is indicated in this disease.

True, over twenty of these thirty-four patients succumbed within two years of their resection; but they had been relieved of their urinary difficulties considers that they were unselected cases, and that only four others died during the third year, I think it may be asserted without fear of contradiction that transurethral resection offers to the vast majority of patients with cancer of the prostate a method of treatment devoid of great risk; free of discomfort, and which leaves them in possession of their normal physiologic function.

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POWDERY MILDEWS AS ALLERGENS*

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THE failure of some hay fever and asthma patients who are sensitive to pollens to react to treatment has long puzzled allergists. That their sensitivity might be due to plant spores other than pollens was not for many years suspected. In the spring of 1939, during a routine study of the deposits on pollen slides exposed daily at various stations on the Mills College Campus, at Oakland, California, an unknown type of spore occurred in great numbers. Careful study of the surrounding vegetation revealed that the source of these spores was a powdery mildew *Microsphæra Alni* (Wallr.) Wint. growing upon the leaves of the Valley Oak (Quercus lobata Nee). In the light of seasonal occurrence of these spores it seemed desirable to test certain individuals with an extract prepared from them. Spores were collected and an extract of their atopens was made with Coca's solution, under the supervision of Dr. Robert K. Cutter at the Cutter Laboratories in Berkeley, California.

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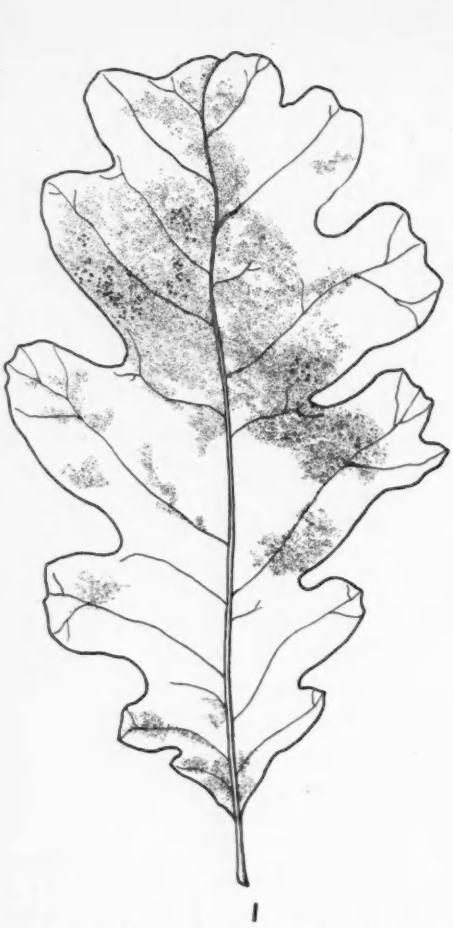

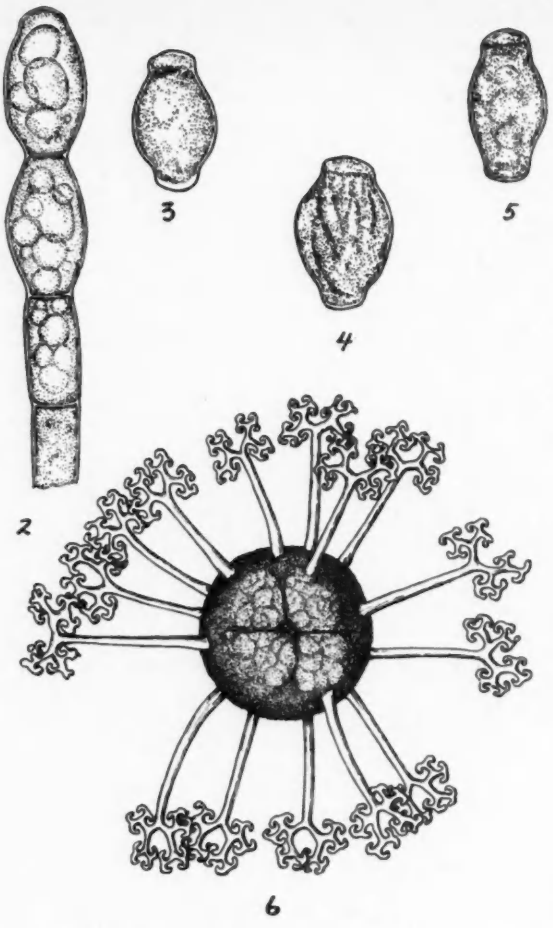

Fig. 1.—Leaf of Quercus agrifolia Nèe, showing mycelium and perithecia. x 1.
Fig. 2.—Conidiophore, with conidiospores being formed. x 600.
Figs. 3, 4, and 5.—Conidiospores. x 600.
Fig. 6.—Perithecium, showing branched appendages. x 900.

CLINICAL MATERIAL

One hundred cases were chosen which showed seasonal symptoms and were known to be sensitive to pollen. The reactions were traced upon cellophane paper and the results are here recorded in Table 1.

The positive reaction to the controls may have been due to the patient's sensitivity to Coca's solution.

Relatively little experimental evidence is available with respect to the part which fungi may play as allergens. Undoubtedly among the active agents in house dust are the spores of such a fungus as *Rhizopus nigricans,* the common black mold of bread. These spores are so abundant that they usually overgrow everything else on culture plates of house dust. A few of the more common molds, such as Penicillium, Aspergillus, etc., as well as certain other fungi, have been tested clinically and have given some positive results.

TABLE 1.—*Reactions in One Hundred Cases*

Number of cases giving 4+ reaction to Microsphæra Alni extract	4
Number of cases giving 3+ reaction to Microsphæra Alni extract	25
Number of cases giving 2+ reaction to Microsphæra Alni extract	23
Number of cases giving 1+ reaction to Microsphæra Alni extract	13
Number of cases giving no reaction	34
Doubtful	1
Total positive reactions	65
Of the controls 89 gave negative results	
10 gave some reaction	
1 was doubtful	

DISTRIBUTION

The large and widespread family Erysiphaceæ, members of which are commonly known as mildews, blights and powdery mildews, has not previously been studied from the point of view of its allergic potentialities. The family belongs to the order Perinosporiales of the Ascomycetes. Its members are all strictly parasitic upon plants. The species are numerous and closely related. Common genera are Sphærotheca, Erysiphe, Phyllactinia, Uncinula, Podosphæra and Microsphæra.

Geographically the powdery mildews are widespread, being particularly abundant in the north temperate zone but occurring from Greenland to

the temperate regions of South America. They attain their best development during the moist periods of the year but they are by no means restricted to humid regions.

HOSTS

The number of known hosts to these parasitic fungi is continually increasing and 2,000 host species is probably a conservative estimate. Some idea of the wide variety of hosts may be obtained from the following very incomplete list, many of which are of economic and horticultural importance: alder, apple, bean, Boston ivy, barberry, birch, clover, Coreopsis, cucumber, currant, dandelion, dahlia, elm, elderberry, Euonymous, Gaillardia, grape, hop, honeysuckle, lupine, marigold, mustard, maple, oak, peach, phlox, pear, pea, poplar, rose, strawberry, tobacco, violet, verbena, willow and walnut, as well as numerous species of grass.

GENERAL CHARACTERISTICS

Many species of these fungi are known to occur in great abundance, and they all have the same general characteristics. The vegetative portion of mycelium is, with few exceptions, superficial to the host, often forming a white or hyaline, felt-like mass over the surface of leaves and young stems. Simple or lobed haustoria enter the stomata or other vulnerable points of the host, and through these the fungus absorbs nourishment. The mycelium is branched and made up of uninucleate cells.

Reproductive bodies produced in the spring and early summer are to be found in large numbers. They are simple, one-celled structures formed in chains on scattered conidiophores (Fig. 2). There is so little morphological difference between the conidiospores (Figs. 3, 4, and 5) of the various species of powdery mildews that these are of little value in their identification. They are usually barrel- or egg-shaped. Under proper conditions of moisture and temperature they will germinate almost immediately, producing a new mycelium and another crop of conidiospores within a few days. These masses of mycelia, with their conidiophores and conidiospores, cause the powdery spots on the leaf surface (Fig. 1). Under proper environmental conditions the conidiospores are released into the air in enormous numbers. They are small, 65-80μ in diameter by 130-150μ in length, and are readily carried by air currents.

Genera and species in the family are distinguished not so much by the conidial characters as by the type of perithecia (Fig. 6) or resting structures resulting from sexual reproduction. They are produced in the fall and appear as black or dark brown spheres just visible to the naked eye. They may occur in abundance. Within them are produced the ascospores which carry the fungus over the unfavorable growing season. *Microsphæra Alni* may be distinguished from all other powdery mildews by the intricately branched appendages (Fig. 6) on the perithecium.

In November, 1939, perithecia in abundance were found on the same oak trees which had produced conidiospores in the spring. The leaves were not yet shed, and the relatively thin white mycelium and many black appendaged perithecia were scattered over the upper leaf surface (Fig. 1). The spores of these fungi may be the cause of many of the baffling and unexplained allergic cases which so frequently appear. The millions of readily dispersable conidiospores produced by a single infection and the great abundance of the fungi of this group on a wide variety of hosts render these plants ideal as a causative agent of asthma and hay fever.

The authors wish to thank Professor H. E. McMinn of Mills College for his coöperation in this work.

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REFERENCES

1. Storm van Leeuwen, W.: Allergic Diseases. Philadelphia: J. B. Lippincott Co., 1925.
2. Brown, G. T.: Hypersensitiveness to Fungi, J. Allergy, 7:455, 1936.
3. Schonwald, Philip: Allergic Molds in the Pacific Northwest, J. Allergy, 9:175, 1938.

COMMON DUCT LESIONS: THEIR SURGICAL MANAGEMENT*

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IT is not the purpose of this paper to present any startling innovation in the management of lesions of the common duct, however much that might be desired. Rather, it is the intent to focus attention upon the fact that we are at present in possession of sufficient information and have at our disposal adequate technical procedures to permit of a somewhat standardized approach to this admittedly difficult field with a view toward the material improvement of our end-results.

Recent advances in our knowledge concerning the normal and abnormal physiology of the liver, the cause and prevention of cholemic bleeding, renewed interest in the hepatorenal syndrome, as well as a realization that the malignant lesions affecting the common duct may be successfully attacked by the same principles of early diagnosis and radical extirpation as are successful in the treatment of cancer elsewhere about the body, have all combined to generate a more optimistic spirit than formerly prevailed.

CLASSIFICATION

Since the ultimate effect of common-duct lesions is to encroach upon or obliterate the lumen of the duct and thus interfere with its function of carrying bile from liver to duodenum, these lesions may be classified as (1) those causing pressure from without, (2) those causing pressure from within the lumen, and (3) those arising within the wall of the duct itself.

Of lesions causing pressure from without, carcinoma of the head of the pancreas is by far the

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most common, followed in frequency by metastatic malignancies arising elsewhere, enlarged glands, Hodgkin's disease, or other lymphoblastomata. Another important cause of obstruction arising from without the duct is chronic interlobular pancreatitis. Stones form the only important cause of obstruction arising within the lumen of the common duct, although instances of obstruction by worms such as ascaris lumbricoides, and liver flukes are on record. Of the disturbances arising within the wall of the common duct itself, benign stricture, usually due to operative trauma, is by far the most frequently seen. Benign tumors, such as papilloma, adenoma, lipoma, fibroma, and neurofibroma, have been recorded, but these are rare. Malignant tumors, while infrequent, are not rare, and are practically always carcinoma.

DIAGNOSTIC PROBLEMS

The most common and prominent symptom of common-duct involvement is jaundice. Thus, the differential diagnosis involves the consideration of all conditions which may give rise to a visible deposit of bilirubin in the tissues. McNee classifies jaundice as follows: (1) hemolytic; (2) hepatogenous; and (3) obstructive. With the first two causes, we are concerned as a matter of elimination. The diagnostic problem in common-duct disorders is to determine, insofar as is possible before operation, the nature and location of the obstructing agent.

The history of a recent surgical attack upon the biliary tract preceding the onset of jaundice, or the presence of an external biliary fistula, are suggestive evidence that the lesion is traumatic, although there must be borne in mind the frequent occurrence of a missed common-duct stone. A positive direct Van den Bergh response indicates, of course, an obstructive type of lesion. But if the jaundice is of considerable duration, the response may not be sharp-cut and may be diphasic, indicating both obstructive and hepatogenous types of jaundice. The galactose tolerance test and the hippuric acid test are of some value in indicating rather marked liver damage. Also, in severe hepatic dysfunction, the blood cholesterol and cholesterol esters are definitely depressed.

STONE AND MALIGNANT OBSTRUCTIONS

The differential diagnosis between stone and malignant obstructions of the common duct is difficult and often impossible to make prior to exploration. Courvoisier's law, which postulates an enlarged soft gall-bladder in the presence of malignant obstruction, and a hard, shrunken gall-bladder in the presence of calculus, are helpful in certain instances, but not entirely reliable. The intermittent nature of the jaundice in calculus disease, together with the chills and fever known as Charcot's syndrome, are of some value in differentiation. Recently, Watson has stressed the importance of the variation in the amount of urobilinogen in urine and feces in the various pathologic instances causing jaundice. He found that in cases of the stone in the common duct there were always present appreciable quantities of urobilinogen in both urine and feces, although these quantities might be somewhat less than those found in normal individuals. However, in obstruction due to malignancy there was found little, if any, urobilinogen in either feces or urine. He stressed the necessity of making these determinations upon specimens collected over five-day periods and averaging the results.

Pain is not a reliable symptom from the standpoint of diagnosis, because of its great variability. Frequent gastro-intestinal hemorrhage in a jaundiced patient is suggestive of carcinoma of the ampulla of Vater. The x-ray sometimes shows a widening of the duodenal "C" in cases of carcinoma of the head of the pancreas, together with other distortion of the duodenal outline, not at all conclusive.

PREOPERATIVE MEASURES

The liver has been called the commissariat of the body. Its functions are many and varied, the most important of these being its rôle in the metabolism of carbohydrate, protein, fat, and vitamins; the secretion of bile; a part played in the process of hemopoiesis; and in the maintenance of substances necessary for the coagulation of blood. Thus, an active preoperative appraisal of its status is essential. In a jaundiced patient the hippuric acid test is of value in estimating the degree of risk. If, following a dose of six grams of sodium benzoate, there is excreted one gram or less of hippuric acid in four hours, surgery is hazardous. If the secretion is five-tenths of a gram or less, surgery is absolutely contra-indicated.

Of cardinal importance is information concerning the bleeding tendency. This is measured by means of the Quick prothrombin clotting time, which estimates the patient's clotting ability as a definite percentage of a normal control, and thus reflects quite accurately any deviation from the normal prothrombin content. This bit of information and its practical application in the prevention of cholemic bleeding are the most recent outstanding contribution to bile-tract surgery. The level of the blood protein is also of importance. In prolonged and severe hepatic damage there is usually a definite decrease in both the blood albumin and the globulin, with a reversal of the usual ratio of two parts of albumin to one of globulin. Renal function and urea clearance should be ascertained. The level of serum bilirubin is important. Operation is less hazardous when performed in the presence of a more or less stabilized serum bilirubin level, even though that be quite high than if done when the level is advancing quite rapidly. Given a jaundiced patient upon whom it is proposed to perform an operation for biliary obstruction, it is highly desirable to restore that patient's liver and renal physiology to as nearly a normal state as possible before the operation is performed.

Diet.—The diet should be high in carbohydrates, containing from 350 to 500 grams daily. Often intravenous glucose is necessary in order to insure that amount. It has been demonstrated by Bollman and Mann that in the experimental dog with biliary obstruction a diet of meat exclusively is not tolerated, but that the same animal will survive months

on a diet of milk and syrup. Meat, or meat extractives, developed ascites in such an animal, but milk and eggs did not favor such a result. Therefore, the daily intake of protein in a jaundiced patient should be from one to two grams of vegetable and dairy protein per kilogram body weight, with the addition of just enough meat to increase the palatability of the diet.

Inasmuch as a damaged liver is unable to handle fat well, the amount of fat should be limited to 45 or 50 grams per day.

The patient with an impaired liver needs larger quantities of vitamins than are contained in normal diets. Walters and Snell, in their book "Diseases of the Gall-bladder and Bile Ducts," recommend the daily administration of oleum percomorphum 30 minims; orange juice,12 ounces; Valentine's extract of liver, 2 ounces; parenteral crystalline thiamin chlorid, 3 to 9 milligrams, brewer's yeast tablets (Harris or Mead), 3 to 5 with each meal. Vitamin K, in the form of Klotogen (Abbott) or some other reliable preparation, should be given in doses of a thousand units three times a day, together with bile salts in doses of at least ten grains three times daily. The prothrombin clotting time should be checked just before operation to assure that it has attained approximately normal values; that is, a clotting time of twenty seconds. In patients with lowered blood protein there is no substitute for transfusion of whole blood or plasma.

POSTOPERATIVE COMPLICATIONS

If the patient has been well prepared, as above outlined, with due regard for the prevention of the two most important postoperative complications, that is, cholemic bleeding and hepatic insufficiency, postoperative care should not be so difficult. Administration of glucose intravenously is still the sheet anchor of postoperative care. Postoperative administration of Vitamin K and bile salts should be continued for several days, unless and until the prothrombin clotting time is shown to be normal. Occasionally, notwithstanding satisfactory preoperative preparation, the symptoms of hepatic insufficiency, or the hepatorenal syndrome, supervene. This condition is to be suspected when the patient becomes stuporous, restless, or the urinary output decreases and the blood urea increases, when jaundice deepens and when drainage from a T-tube, which had formerly been satisfactory, becomes thin and watery.

Oxygen is of value, together with transfusion, to improve the oxygen transport system of the blood. If these measures fail, the intravenous use of one or two per cent sodium lactate in normal salt, 1,000 cubic centimeters once or twice daily, is often useful.

Postoperative atelectasis, as the forerunner of postoperative pneumonia, should always be considered in the presence of a rapid pulse with cyanosis or evidence of respiratory embarrassment. For the treatment of postoperative shock, next in value to transfusion of whole blood or plasma, is a 6 per cent solution of acacia in normal salt, 500 cubic centimeters given intravenously.

TRAUMATIC STRICTURES

The best treatment for stricture or other abnormalities of the common duct, consequent upon operative trauma, is their prevention. To avoid such injuries an intimate knowledge of the usual anatomy of the extrahepatic biliary tract, and the structures of the hepatoduodenal ligament together with their frequent variations, is essential. In operating upon these structures, it is inexcusable to sever or ligate any one of them without making absolutely sure of its relationship to the other vital parts. Probably the most common error in this connection is the ligation of the right hepatic artery in place of the cystic artery, thus diminishing greatly, if not completely stopping, the blood supply to the right lobe of the liver, and often causing death, with symptoms usually ascribed to hepatic insufficiency or the so-called "liver death," which is not in reality a liver death at all in the accepted sense.

Another disastrous mechanical error is the partial or complete severance of the common duct because of its inclusion in the clamp around the cystic duct. Whether one performs the operation of cholecystectomy from below upward, or from above downward, makes very little difference, provided he uses that technique with which he is thoroughly familiar and follows the cardinal principles of identifying the anatomy before severing or ligating any structure.

Another important prophylactic point in all attacks upon the common duct is to explore the duct thoroughly and ascertain insofar as possible the kind of abnormality present before the gall-bladder is sacrificed. This will permit a later anastomosis of the gall-bladder to the intestinal tract in case the common-duct lesion is such as to preclude its removal and at the same time maintain duct continuity. Complete severance of the common or hepatic duct occurring during surgery, and recognized at the time, should be repaired immediately by suturing around a T-tube.

Benign common-duct stricture following surgical trauma presents itself in several different forms, depending upon the level at which the duct is occluded. The simplest is the narrow annular stricture occurring in the readily accessible portion of the duct. This is best treated by a longitudinal incision through the stricture and transverse closure. Complete occlusion of the common duct below the cystic duct, under circumstances which permit the mobilization of the proximal and distal ends, is repaired by interrupted sutures around a T-tube. This usually gives excellent results, provided undue tension can be avoided by satisfactory mobilization of the divided ends. If it is impossible to mobilize enough of the distal end to permit satisfactory anastomosis, then the common duct or the hepatic duct must be implanted into the duodenum or the jejunum, a process being known as choledocho or hepatico-enterostomy, performed after the method of W. J. Mayo. Usually a rubber tube or catheter is employed as a foundation for such anastomosis, and in order to insure the patency of

the opening while healing occurs. In instances in which the occlusion lies high in the hepatic duct, or involves both the right and left hepatic ducts, it is sometimes necessary to implant these ducts separately into the duodenum or jejunum, this procedure often being technically very difficult.

The Kehr operation is suggested for those instances in which it is impossible to identify either right or left hepatic duct for the purpose of anastomosis with the intestinal tract. This is performed by denuding an area on the under surface of the right lobe of the liver about one by two inches; then with deep thrusts of the pencil-tip, cautery openings are made into the substance of the liver, thus opening up several bile radicals. A loop of jejunum is anastomosed snugly to the area of liver so denuded. This operation is called hepatojejunostomy. Its application is very limited, and its success highly questionable.

The implantation of an external biliary fistula into the duodenum or jejunum has been successfully accomplished on several occasions. The fistula is mobilized by careful dissection sufficiently to permit its introduction and suture into the duodenum or jejunum. Lahey has emphasized the necessity of leaving as much of the fistula as possible in contact with the under surface of the liver in order to facilitate its blood supply. All of the implantation operations are subject to the frequent occurrence of ascending cholangitis and the development of stricture in the anastomoses so formed, but they do offer considerable to a patient afflicted with this kind of biliary obstruction.

On my service at the Los Angeles County General Hospital a year ago, I performed an hepaticoduodenostomy on a woman for a lesion of the common duct not amenable to other repair. Her postoperative course was not particularly stormy. From time to time, she experiences some distress in the upper abdomen, with slight jaundice and low-grade fever. Her stools are normal in color. She is undergoing recurrent attacks of low-grade cholangitis, but it is believed her ultimate outlook is good.

STONE IN THE COMMON BILE DUCT

Stone in the common bile duct occurs far more frequently than was formerly believed. Authorities differ in their estimates of frequency, some stating that one patient in five suffering with stones in the gall-bladder has common-duct stones, while others place the estimate as high as one in three. As the result of this viewpoint, more common ducts are being explored for stone in connection with the operation of cholecystectomy for stones in the gall-bladder. It is pretty generally agreed that, in addition to the cholecystectomy for stones in the gall-bladder, the common duct should be explored in patients giving history of rather intense or prolonged jaundice, intermittent fever, and in whom the common duct is enlarged, thickened, or is seen to have lost its normal bluish color. Some operators go as far as to contend that all common ducts should be explored in the presence of stones in the gall-bladder.

The removal of a stone from the comon duct may be very easy or extremely difficult. It is not our purpose to outline at length the various technical maneuvers involved, but it may be said that in this field of surgery one's ingenuity is taxed to the utmost.

Supraduodenalcholedochotomy, retroduodenalcholedochotomy preceded by the mobilization of the duodenum by the method of Kocher, transduodenalcholedochotomy, all have their places and particular indications. It is our custom to drain the common duct with a T-tube in every instance in which it is opened or explored.

One of the most annoying features of surgery for stone in the common duct is the stone that was missed at operation. This is to be suspected when, following cholecystectomy or choledochotomy, the patient develops upper abdominal pain, intermittent fever, and jaundice. To obviate overlooking a stone at operation, there has developed the practice of cholangiography. Lipiodol or hippuran is injected and an x-ray taken immediately. This entails some time and inconvenience, but is often worth the effort.

BILIARY DYSKINESIA

Both the medical and surgical literature during the past few years have contained frequent references to a condition called biliary dyskinesia. This term describes a spasm of the sphincter of Oddi, and is used in explanation of the poor result notoriously known to follow cholecystectomy for chronic cholecystitis without stones. Working upon this principle, Colp, Doubilet, and Gerber, at the Mount Sinai Hospital, have developed an instrument for the incision of the sphincter of Oddi through the common duct. They have reported several favorable instances of the use of this instrument and contend that it is perfectly safe. Their instrument is introduced through the ordinary choledochotomy incision, directed into the duodenum and then pulled backward, upon which a projecting tooth-like blade engages in the upper portion of the sphincter and removes a small wedge-shaped piece of that structure. Working entirely independently and antedating the work of Colp, Doubilet, and Gerber, according to his statement, Otto DeMuth of Vancouver has developed an instrument for the same purpose, but of a slightly different construction. His instrument is the usual olive-tipped bougie in which is fashioned a small knife. The function of the knife is to incise the sphincter Oddi, but not to excise a portion of its tissue; thus DeMuth claims that the possibility of hemorrhage is entirely obviated. This instrument has particular bearing upon the problem of missed stone in the common duct. It is stated by DeMuth that he has not had an instance of recurrent or missed stone in the common duct since the use of his instrument, inasmuch as the relaxed sphincter of Oddi makes it very easy for the common duct to expel such a stone. There should be mentioned, in passing, also the operation of Reich, in which the sympathetic innervation of the sphincter of Oddi is destroyed by careful dissection of the plexus around the lower end of the common duct.

RETAINED STONE

If, during the postoperative course of a patient with a T-tube in his common duct, there is reason to suspect the presence of a retained stone, cholangiography is performed. If such a stone is shown to be present, it may be fragmented and dislodged by the method of Pribram, consisting of the instillation of 2 to 3 cubic centimeters of ether into the T-tube and the administration of amylnitrite by inhalation. Best, of Omaha, has done considerable work in this field and has developed a technique that he calls his flush of the bile tract. This consists essentially of the use of nitroglycerin or amylnitrite, Epsom salts, and olive oil, by mouth or by duodenal tube, and atropin by mouth or hypodermic. Quite often it is possible to dislodge and expel a retained stone by these methods. Their failure, of course, indicates reoperation, which is always a much more hazardous and difficult procedure than the original operation.

Benign neoplastic lesions are very rare. When they occur in accessible locations in the duct, they can be removed by segmental resection and anastomosis of the duct over a T-tube.

Malignant lesions, practically always carcinoma, while not frequent are not rare. They may occur in any location along the course of the duct from either the right or left hepatic duct, their juncture, the juncture of the common hepatic with the cystic and along the course of the common duct or in the ampulla of Vater.

CHRONIC INTERLOBULAR PANCREATITIS

One important condition causing obstruction to the common duct by pressure from without is chronic interlobular pancreatitis. It is said that this is most often due to present or previous stone in the common duct or in the pancreatic duct, but often at operation the stone cannot be detected. The patient presents a history of gradually increasing jaundice, with vague upper abdominal distress. At operation the external biliary tract is found to be essentially normal, except that the common duct and gall-bladder may be somewhat dilated. There is found a rather hard, diffuse mass in the head of the pancreas. Exploration of the common duct reveals no stone, but some obstruction due to the pressure of this mass. The difficulty lies in differentiating between chronic pancreatitis and carcinoma of the head of the pancreas. This is often impossible at the operating table. One case history will illustrate this condition.

REPORT OF CASE

The patient was a well-developed white female, age thirty-eight years, who consulted me in 1933, complaining of abdominal pain, nausea, and vomiting, with an onset of about nine weeks previously. She had been quite jaundiced at times. She complained of sour stomach, pain occurring about four hours after meals; had lost twelve pounds during the period of her illness. Examination revealed slight visible jaundice, with some tenderness over the gall-bladder region. X-ray examination revealed a poorly functioning gall-bladder, but showed no stones. At operation the gall-bladder was found to be rather markedly dilated, soft, and contained no stones. The common duct was dilated, but no stones were palpable. There was a mass in the head of the pancreas about the size of a hen's egg, irregular, nodular, firm. The remainder of the pancreas was firmer than normal. A small piece of the pancreas was removed for biopsy. This removal occasioned considerable sharp hemorrhage, which was finally controlled by suture. The biopsy showed only chronic pancreatitis, but it was felt at the time that a representative portion of the gland had not been obtained; therefore, the diagnosis at the table was carcinoma. A cholecystduodenostomy was performed. The patient's postoperative convalescence was uneventful. In September, 1934, or fifteen months after the operation, she was delivered of a normal infant. Today her health is entirely satisfactory. She shows no symptoms referable to the gastro-intestinal tract or any evidence of metastatic malignancy; thus confirming the diagnosis of chronic pancreatitis.

LOS ANGELES COUNTY GENERAL HOSPITAL STATISTICS

At the Los Angeles County General Hospital, from the years 1929 to 1938 inclusive, there were 124 instances of carcinoma involving the head of the pancreas, the common duct, or the ampulla of Vater. Of these, 112, or 90.4 per cent, involved the head of the pancreas; nine, or 7.2 per cent, the common duct; and three, or 2.4 per cent, involved the ampulla of Vater. Thus, there is seen the great preponderance of these lesions in the head of the pancreas.

An effort was made to determine from the records of these patients their operability from the standpoint of radical removal of the pathologic process. In the records of seventy-five of these patients there was sufficient information on which to base an opinion. Of these seventy-five, there were thirty-two with definite local or distant metastasis—42.6 per cent. There were forty-three, or 57.4 per cent, without local or distant demonstrable metastasis; thus, almost 60 per cent of these patients, presumably, were entitled to an attempt at radical removal of their carcinoma. While in rare instances it might be possible to excise a well-localized malignancy of the free portion of the common duct and effect an end-to-end anastomosis of the severed ends, such a local incision would not conform to the accepted principles for the treatment of cancer; that is, widespread removal of the growth and surrounding tissues. Also, there are a number of instances on record of local removal of a carcinoma in the ampullary region, but such removals have practically always been followed by early recurrence.

WHIPPLE PANCREATICODUODENECTOMY

It is to deal with the problem of carcinoma in the region of the head of the pancreas, in accordance with the modern accepted principles of radical widespread excision, that the Whipple pancreaticoduodenectomy has been devised. Fundamental to the use of this operation is the understanding, proved by animal experimentation and subsequent clinical operation or observation, that the external secretion of the pancreas is not essential for life or a fair degree of health.

Since it is usually difficult, if not impossible, to differentiate at operation between a malignancy of the common duct and one arising in the head of the pancreas, and since this distinction is of no particular importance as regards the procedure to be

employed, the only important considerations are to determine whether or not local or distant spread has occurred. Otherwise, with a patient in fairly good condition and satisfactory preoperative preparation, the Whipple operation is the procedure of choice if one wishes to make an attempt to cure his patient. It is a prolonged operation, quite shocking, but the ends to be achieved are worth the risk. It is performed in two stages. The first stage consists of double ligation of the common duct with heavy linen and its incision between these ligatures. The ligature on the distal end is left long for identification at the second stage. The small bowel is divided about 12 to 15 inches distal to the ligament of Treitz, an end-to-side enterostomy is performed, and the fundus of the gall-bladder is anastomosed to the distal end of the jejunum. This is all of the first stage. The second stage is performed two or three weeks later, following satisfactory recovery from the first operation. The distal end of the severed common duct is identified by its long ligature. Posterior gastroenterostomy is performed. The gastroduodenal artery is identified and ligated. The entire duodenum and a large wedge-shaped portion of the head of the pancreas are excised en bloc. The ducts of Santorini and Wirsung are ligated with heavy silk or linen, and the pancreatic remnant is ligated with interrupted sutures of silk. One drain is placed in the pancreatic bed so formed. While this operation is indeed radical and its immediate mortality high, it offers the only present opportunity for complete radical cure of malignant lesions in this region.

In a recent personal communication, Doctor Whipple stated that his present tendency is to perform the entire operation in one stage in individuals who are in good condition and seem able to tolerate it. The only feasible alternative procedure is an anastomosis between the gall-bladder and the intestinal tract, preferably the duodenum. This is to be performed when the growth has extended beyond limits permitting of its radical removal, or when the patient's condition will not permit consideration of the Whipple operation. It offers, at best, only temporary palliation, records showing that the average life expectancy after these palliative procedures is about seven and a half months.

SUMMARY

In the surgical management of lesions of the common duct, a thorough understanding of normal and abnormal liver physiology is essential.

Recent advances in our knowledge of liver function are applied to common-duct obstruction.

The surgical treatment of operative strictures and the management of common-duct stones are outlined.

Missed stone and its treatment are discussed.

The principles used in the successful treatment of carcinoma of the body elsewhere are equally applicable to carcinoma involving the common duct and its neighboring structures.

The Whipple operation presents a practical application of these principles.

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SYPHILIS: FIVE-DAY TREATMENT*

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THE five-day treatment of syphilis, as introduced by Hyman, Chargin, and Leifer,[1] represents an attempt to eradicate early syphilis by means of a massive dose of an arsenical spirocheticide administered intravenously by the continuous drip method. In 1931 Hirschfeld, Hyman, and Wagner[2] showed that large amounts of a toxic substance may be given intravenously without untoward reactions, provided this substance is introduced into the blood stream with sufficient slowness. They concluded that many of the toxic reactions which follow intravenous injections are the result of speed shock. Applying this principle to the treatment of early syphilis, Hyman, Chargin, and Leifer have attempted to reach Ehrlich's original goal, namely, the total sterilization of the patient from spirochetes by one massive dose of arsphenamin.

STUDIES AT MOUNT SINAI HOSPITAL

A symposium on this subject held at Mount Sinai Hospital, New York City, on April 12, 1940, created considerable interest in this work, among both medical men and the lay public. The importance of this investigation is indicated by Moore,[3] who, in discussing the papers presented on that occasion, stated: "This investigation may represent the most important advance in the treatment of syphilis since the original discovery of arsphenamin by Ehrlich in 1909." This method of treatment is still in the experimental stage and is being investigated by the group of workers at Mount Sinai Hospital. At this institution an organization has been set up for the proper execution of the technique and for a thorough follow-up of the patients from both the clinical and the laboratory standpoint. We agree with these workers that the administration of this treatment should be confined to that institution until its merits and dangers have been completely evaluated.

The purpose of this paper is to present a critical review of the published reports and to comment on certain aspects of the problems involved.

REVIEW OF PUBLISHED REPORTS

As a result of the symposium at Mount Sinai Hospital, a series of nine papers[3] was published in August, 1940, which presents the most recent data on massive arsenotherapy in early syphilis (the five-day treatment of early syphilis).

Method of Treatment.—From 1933 to 1938, neoarsphenamin was used in treating ninety-three patients with primary or secondary syphilis by the five-day method. A freshly prepared solution, consisting of 0.1 gram neoarsphenamin dissolved in 100 cubic centimeters of 5 per cent glucose, was administered by intravenous drip at the rate of

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TABLE 1.—*Therapeutic Results Obtained With Neoarsphenamin*

Patients	Duration of Follow-up Study	Number of Patients Treated	Negative Serologic Reactions; Clinical Cures		Failures;* Clinical or Serologic Relapse	Maximum Per Cent of Failure
1933 group	6 years	15	13	86%	2	13.4
1937 group	2 years	78	71	91%	7	9.0
Total		93	84	90.3%	9	9.7

* Including doubtful seropositive results.

3 cubic centimeters per minute for ten hours a day during five successive days. Thus, the total dose of neoarsphenamin was 4 to 4.5 grams. Because of a death from hemorrhagic encephalitis following this treatment, mapharsen, being considered a less toxic drug, was substituted for neoarsphenamin in 1938. With the exception of one, all patients treated were males.

Two series of patients were treated with neoarsphenamin, one group in 1933 and the other in 1937. The former was followed for six and the latter for two years. Table 1 shows the therapeutic results obtained with neoarsphenamin.

All the patients who were lost, from observation, are included in the percentage of maximum failure, and those in whom there was any doubt as to the therapeutic results were classified as failures. Even with this rigid analysis, the percentage of clinical cures was high, *i. e.*, 90.3 per cent.

Toxic Effects from Neoarsphenamin.—Many toxic reactions were encountered in the patients treated with neoarsphenamin. The untoward effects from both neoarsphenamin and mapharsen as given by Chargin are listed in Table 2.

The incidence of primary and secondary fever, transient erythema, jaundice, and peripheral neuritis was rather high. In the primary, or Herxheimer fever, the temperature rose sharply, averaging 102 degrees Fahrenheit on the first day of treatment; it usually subsided to normal by the next morning. The highest temperature noted in primary fever was 105 degrees Fahrenheit, and the longest duration was four days. The secondary fever appeared toward the end of the treatment period; the temperature averaged 102.8 degrees Fahrenheit for four days, the highest temperature was 105.4 degrees Fahrenheit and the longest duration ten days. In some cases the secondary fever was accompanied by erythema. The toxicoderma was mild, of short duration and did not sensitize the patient to the drug. The high percentage of this reaction is noteworthy. The incidence of peripheral neuritis (35 per cent) in patients treated with neoarsphenamin was exceedingly high, and while in most cases the reaction was mild it lasted for four to six months in seve al instances.

It is obvious from Table 2 that the percentage of toxic reactions caused by mapharsen was much smaller than that brought about by neoarsphenamin. Mapharsen, therefore, may be considered a safe drug for this purpose.

Treatment with Mapharsen.—As previously stated, treatment with mapharsen was begun in the fall of 1938. At first, 10 per cent of the dose of neoarsphenamin, or 400 milligrams, was given. Because of the low toxicity, the dose was slowly increased to 1,200 milligrams. The patients treated were divided into two groups. *Group A* consisted of 157 patients, who received less than 1,200 milligrams of mapharsen and were followed for eighteen months. Of these, twenty-four received

TABLE 2.—*Untoward Effects from Neoarsphenamin and Mapharsen*

	Neoarsphenamin		Mapharsen	
	Number	Per Cent	Number	Per Cent
Total treatment courses 399 treatment cases	111		288	
Primary fever	69	62	116	40
Secondary fever	71	64	36	12
Toxicoderma	50	45	33	11
Dermatitis exfoliativa	1	0.9	0	0
Blood dyscrasias	0	0	0	0
Renal damage	0	0	0	0
Jaundice	4	3.6	2	0.7
Peripheral neuritis	39	35	5	1.6
Cerebral symptoms	2	1.8	3	1.04
Hemorrhagic encephalitis	(1)	(0.9)	(1)	(0.34)
Single convulsions	(1)	(0.9)	(1)	(0.34)
Disorientation	(0)	(0)	(1)	(0.34)
Fatality	1	0.9	0	0

less than 600 milligrams; thirty received approximately 700 milligrams; twenty-seven, 800 milligrams; forty-nine, 1,000 milligrams; and twenty-seven, 1,100 milligrams. *Group B* consisted of one hundred patients, who received 1,200 milligrams of mapharsen and were followed for only six months. An evaluation of the therapeutic results obtained in Group A showed satisfactory results in 72 per cent. This number included all those who were classified as failures. The period of observation in Group B has been too short to evaluate the therapeutic results. To the present time the therapeutic results from mapharsen appear inferior to those from neoarsphenamin, although the toxicity of the former is definitely less than that of the latter.

COMMENT

The proponents of massive arsenotherapy in early syphilis set forth its advantages as follows:

1. By this method the infectious lesions of early syphilis are rapidly sterilized. Treponema pallida disappear within twenty-four to forty-eight hours, and the lesions remain free of spirochetes and heal rapidly.

2. Only five days are required to complete the course of treatment. Thus, the prolonged treatment over a period of two or three years, necessitated by the present methods of multiple injections, is eliminated.

3. All patients who are placed under treatment complete their course. In contrast, 20 to 80 per cent of the patients treated by the usual methods disappear from observation before therapy is completed.

4. The percentage of satisfactory therapeutic results is as great, or greater, than in the methods now in use.

5. A massive sterilizing dose of a spirocheticide accomplishes the primary aim of Ehrlich.

6. Administration of massive doses of the arsphenamins by the continuous drip method eliminates the phenomenon of speed shock.

7. Serious toxic reactions may be avoided by substituting mapharsen for neoarsphenamin.

The disadvantages of the massive arsenotherapy in early syphilis may be stated as follows:

1. The five-day treatment is still in the experimental stage. It should, therefore, be thoroughly investigated in hospitals equipped to carry out the procedure and to do proper follow-up studies before it is submitted for general application by practicing physicians and by clinics. A period of several years will probably be required to accomplish this.

2. It is a hospital procedure and entails considerable expense.

3. Sufficient time has not elapsed to evaluate the final therapeutic results and the toxic end-effects.

4. Neoarsphenamin is too toxic to be practical for application by this method.

5. Mapharsen is definitely less toxic than neoarsphenamin and may be used in its place. However, it has been employed for too short a time to determine its therapeutic value. To date, the therapeutic results with mapharsen have not been as satisfactory as those reported with the use of neoarsphenamin.

6. This method has been employed only in males with early syphilis. Therefore, no data are available as to its value in the treatment of early syphilis in females, of latent syphilis, or of the numerous manifestations in late syphilis.

Two other points mentioned in these publications[3] warrant further discussion. The original investigators state that 4 to 4.5 grams of neoarsphenamin may be given by the massive dose method in five days, while three months are required for this dosage by the usual methods of antisyphilitic treatment. I wish to point out that by the usual methods of treatment of early syphilis we administer 4.35 grams of neoarsphenamin in six weeks; in some clinics an even higher dosage is used. I am certain that, if it seemed advisable, this dosage could safely be increased further by the use of the multiple injection method.

Secondly, I disagree with the statement that the incidence of hemorrhagic encephalitis in the cases reported,[3] namely, two in 350 with death in one, is not excessive. The authors quote Cole[4] as reporting that the incidence of deaths due to hemorrhagic encephalitis in syphilis treated by the usual methods is one in 200 cases. Moore pointed out that hemorrhagic encephalitis was noted at Johns Hopkins Hospital in only one of 15,000 cases under treatment. Stokes[5] stated that a mortality rate from all causes of one in 15,000 to 35,000 injections of the arsphenamins may be considered good technical performance. Under the most favorable conditions the unavoidable risk of antisyphilitic treatment is much less. Since hemorrhagic encephalitis is responsible for 50 per cent of all deaths due to the arsphenamins, fatalities as a result of this reaction are obviously rare. This finding coincides with the experience we have had at the University of California Clinic. During the past fifteen years we have encountered death from hemorrhagic encephalitis as a result of treatment with the arsphenamins in only one case.

CONCLUSIONS

Massive arsenotherapy of syphilis is at present entirely experimental. Many years of investigation are required before its true value in the treatment of syphilis can be determined. It has been tried only in the primary and secondary stages of syphilis in the male.

This method of antisyphilitic treatment should not be used by physicians or clinics in general. It should be employed only in institutions equipped to carry out the technique of the procedure and, what is more important, to follow the patients for a sufficient period of time to evaluate the therapeutic effects.

Much work must be done both clinically and on experimental animals before the most effective dose of the drug and the most advantageous period of treatment can be determined.

The five-day treatment of syphilis opens up a new avenue of approach to the control of early syphilis, and is an important contribution to the study of the problem of antisyphilitic therapy.

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REFERENCES

1. Hyman, H. T., Chargin, L., and Leifer, W.: Massive Dose of Arsenotherapy of Syphilis by Intravenous Drip Method: Five-Year Observations, Am. J. Med. Sci., 197: 480 (April), 1939.

2. Hirschfeld, S., Hyman, H. T., and Wagner, J. J.: Influence of Velocity on Response to Intravenous Injections, Arch. Int. Med., 47:259 (Feb.), 1931.

3. Conference on Massive Arsenotherapy in Early Syphilis by Continuous Intravenous Drip Method, Arch. Derm. and Syph., 42:239-283 (Aug.), 1940. (*a*) George Baehr, The preliminary work with neoarsphenamin. (*b*) W. Leifer, Technic. (*c*) L. Chargin, Toxicological manifestations. (*d*) H. T. Hyman, Clinical considerations. (*e*) J. F. Mahoney, Résumé of serologic observations. (*f*) B. Webster, Follow-up observations at New York Hospital. (*g*) E. Thomas, Follow-up observations at Bellevue Hospital. (*h*) H. Sobotka, W. Mann, and E. Feldbau, Arsenic excretion in the urine and concentration in the blood. (*i*) J. F. Rice, Public health aspects.

4. Cole, H. H., et al.: Toxic Effects Following Use of Arsphenamin, J. A. M. A., 97:897 (Sept. 26), 1931.

5. Stokes, J.: "Modern Clinical Syphilology." Philadelphia: W. B. Saunders Company, 1934.

RECURRENT LYMPHANGITIS*

REPORT OF A CASE WITH UNUSUAL FEATURES

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L. F. X. Wilhelm, M. D.
Los Angeles

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* Read before the Section on Dermatology and Syphilology at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

REPORT OF CASE

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It is the first case we have observed in which an eczematoid eruption was definitely a part of the syndrome of recurrent lymphangitis. The eruption was always synchronous with the febrile attack, indicating an etiologic relationship. Previous studies of our own and those of other observers point to the streptococcus or possibly to a mixed infection in the lymphatics as the cause of recurrent lymphangitis. Therefore, this case adds marked evidence to the conception that a focus of pyogenic infection can play at least a part in the production of an eczema. We are not unmindful, however, of the complex interplay of such an infection with the trichophyton, external irritation, and possibly some associated systemic abnormality, which Wise [2] has so beautifully emphasized in regard to vesicular eruptions of the hands and feet. It is evident that the patient's skin had undergone an allergic change, as shown by his hypersensitiveness to banal external irritants, to sulfanilamide with its ready production of photosensitiveness, and his very active response to trichophytin. Whatever the exact mechanism, there is no doubt that activity of the infection focus in the lymphatics acted as the precipitating cause, as the match, as it were, that produced the explosion.

We hope this case will serve to call particular attention to the syndrome of recurrent lymphangitis, to the end that its early recognition, on which depends much of its successful treatment, may penetrate wider medical circles, especially the general field. Long duration does not make the prognosis hopeless, however, as this case illustrates.

less than 600 milligrams; thirty received approximately 700 milligrams; twenty-seven, 800 milligrams; forty-nine, 1,000 milligrams; and twenty-seven, 1,100 milligrams. *Group B* consisted of one hundred patients, who received 1,200 milligrams of mapharsen and were followed for only six months. An evaluation of the therapeutic results obtained in Group A showed satisfactory results in 72 per cent. This number included all those who were classified as failures. The period of observation in Group B has been too short to evaluate the therapeutic results. To the present time the therapeutic results from mapharsen appear inferior to those from neoarsphenamin, although the toxicity of the former is definitely less than that of the latter.

COMMENT

The proponents of massive arsenotherapy in early syphilis set forth its advantages as follows:

1. By this method the infectious lesions of early syphilis are rapidly sterilized. Treponema pallida disappear within twenty-four to forty-eight hours, and the lesions remain free of spirochetes and heal rapidly.

2. Only five days are required to complete the course of treatment. Thus, the prolonged treatment over a period of two or three years, necessitated by the present methods of multiple injections, is eliminated.

3. All patients who are placed under treatment complete their course. In contrast, 20 to 80 per cent of the patients treated by the usual methods disappear from observation before therapy is completed.

4. The percentage of satisfactory therapeutic results is as great, or greater, than in the methods now in use.

5. A massive sterilizing dose of a spirocheticide accomplishes the primary aim of Ehrlich.

6. Administration of massive doses of the arsphenamins by the continuous drip method eliminates the phenomenon of speed shock.

7. Serious toxic reactions may be avoided by substituting mapharsen for neoarsphenamin.

The disadvantages of the massive arsenotherapy in early syphilis may be stated as follows:

1. The five-day treatment is still in the experimental stage. It should, therefore, be thoroughly investigated in hospitals equipped to carry out the procedure and to do proper follow-up studies before it is submitted for general application by practicing physicians and by clinics. A period of several years will probably be required to accomplish this.

2. It is a hospital procedure and entails considerable expense.

3. Sufficient time has not elapsed to evaluate the final therapeutic results and the toxic end-effects.

4. Neoarsphenamin is too toxic to be practical for application by this method.

5. Mapharsen is definitely less toxic than neoarsphenamin and may be used in its place. However, it has been employed for too short a time to determine its therapeutic value. To date, the therapeutic results with mapharsen have not been as satisfactory as those reported with the use of neoarsphenamin.

6. This method has been employed only in males with early syphilis. Therefore, no data are available as to its value in the treatment of early syphilis in females, of latent syphilis, or of the numerous manifestations in late syphilis.

Two other points mentioned in these publications[3] warrant further discussion. The original investigators state that 4 to 4.5 grams of neoarsphenamin may be given by the massive dose method in five days, while three months are required for this dosage by the usual methods of antisyphilitic treatment. I wish to point out that by the usual methods of treatment of early syphilis we administer 4.35 grams of neoarsphenamin in six weeks; in some clinics an even higher dosage is used. I am certain that, if it seemed advisable, this dosage could safely be increased further by the use of the multiple injection method.

Secondly, I disagree with the statement that the incidence of hemorrhagic encephalitis in the cases reported,[3] namely, two in 350 with death in one, is not excessive. The authors quote Cole[4] as reporting that the incidence of deaths due to hemorrhagic encephalitis in syphilis treated by the usual methods is one in 200 cases. Moore pointed out that hemorrhagic encephalitis was noted at Johns Hopkins Hospital in only one of 15,000 cases under treatment. Stokes[5] stated that a mortality rate from all causes of one in 15,000 to 35,000 injections of the arsphenamins may be considered good technical performance. Under the most favorable conditions the unavoidable risk of antisyphilitic treatment is much less. Since hemorrhagic encephalitis is responsible for 50 per cent of all deaths due to the arsphenamins, fatalities as a result of this reaction are obviously rare. This finding coincides with the experience we have had at the University of California Clinic. During the past fifteen years we have encountered death from hemorrhagic encephalitis as a result of treatment with the arsphenamins in only one case.

CONCLUSIONS

Massive arsenotherapy of syphilis is at present entirely experimental. Many years of investigation are required before its true value in the treatment of syphilis can be determined. It has been tried only in the primary and secondary stages of syphilis in the male.

This method of antisyphilitic treatment should not be used by physicians or clinics in general. It should be employed only in institutions equipped to carry out the technique of the procedure and, what is more important, to follow the patients for a sufficient period of time to evaluate the therapeutic effects.

Much work must be done both clinically and on experimental animals before the most effective dose of the drug and the most advantageous period of treatment can be determined.

The five-day treatment of syphilis opens up a new avenue of approach to the control of early syphilis, and is an important contribution to the study of the problem of antisyphilitic therapy.

450 Sutter Street.

REFERENCES

1. Hyman, H. T., Chargin, L., and Leifer, W.: Massive Dose of Arsenotherapy of Syphilis by Intravenous Drip Method: Five-Year Observations, Am. J. Med. Sci., 197: 480 (April), 1939.

2. Hirschfeld, S., Hyman, H. T., and Wagner, J. J.: Influence of Velocity on Response to Intravenous Injections, Arch. Int. Med., 47:259 (Feb.), 1931.

3. Conference on Massive Arsenotherapy in Early Syphilis by Continuous Intravenous Drip Method, Arch. Derm. and Syph., 42:239-283 (Aug.), 1940. (*a*) George Baehr, The preliminary work with neoarsphenamin. (*b*) W. Leifer, Technic. (*c*) L. Chargin, Toxicological manifestations. (*d*) H. T. Hyman, Clinical considerations. (*e*) J. F. Mahoney, Résumé of serologic observations. (*f*) B. Webster, Follow-up observations at New York Hospital. (*g*) E. Thomas, Follow-up observations at Bellevue Hospital. (*h*) H. Sobotka, W. Mann, and E. Feldbau, Arsenic excretion in the urine and concentration in the blood. (*i*) J. F. Rice, Public health aspects.

4. Cole, H. H., et al.: Toxic Effects Following Use of Arsphenamin, J. A. M. A., 97:897 (Sept. 26), 1931.

5. Stokes, J.: "Modern Clinical Syphilology." Philadelphia: W. B. Saunders Company, 1934.

RECURRENT LYMPHANGITIS*

REPORT OF A CASE WITH UNUSUAL FEATURES

W. H. Goeckerman, M. D.
AND
L. F. X. Wilhelm, M. D.
Los Angeles

THE subject of lymphangitis is given scant treatment in textbooks on dermatology. In those on internal medicine and surgery it receives usually a few more lines, but in none at our disposal have we been able to find a detailed description of the topic under consideration. Recurrent lymphangitis, as the term is used here, is undoubtedly a clinical and biologic entity. Its cardinal characteristics are a diffuse, occasionally streaked erythema, involving any part of the body, but showing sites of predilection, and most commonly seen on the lower extremities. This erythema may cover a patch the size of a silver coin or completely involve two extremities or more; usually it is associated with some edema. Hence, it frequently has been referred to as chronic or recurrent erysipelas. During an attack the erythema frequently, although not always, is associated with palpable enlargement of the satellite glands. In very mild infections there may be no demonstrable rise of temperature, but usually there is a fever of 102 to 103 degrees Fahrenheit and we have seen an occasional rise to 106 degrees Fahrenheit. This syndrome might be simulated by other types of infection, but its most distinctive characteristic is its self-limited course, which varies from two to six days. Such an attack recurs every week or two or at intervals of several months, always shows the same characteristics, and in due time results in considerable thickening of the tissues and a veritable elephantiasis. Gans,[1] while he does not sharply depicture this syndrome, gives an accurate description of its histopathology in his chapter on early and late elephantiasis. This clinical syndrome is a reasonably common one, although probably not clearly recognized by the average practitioner; and, if personal experience can be relied upon, not even by all dermatologists. The case reported here, however, has shown some unusual features, observed by us in only this one patient out of a total of more than thirty.

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GENERAL COMMENT

Nearly thirty-five years ago one of the writers became specially interested in the problem under discussion as a clinical curiosity. This came about as the result of this syndrome's presence in a personal friend, who at that time consulted a large number of physicians, including several with the most famous names of that period. All efforts at treatment proved vain, however, and the attacks occurred without abatement for many years. The usual elephantiasic enlargement resulted, for which some relief was given by surgical interference. He is, today, a man of about sixty years, and while he has had no active attacks for a number of years, they have proved a very marked handicap for a good share of his active life. In retrospect, it may be said that the problem was not understood and, hence, efforts at treatment were misdirected. Since then the same writer (W. H. G.)[3] retained his interest, and in 1930 reported his observations on seventeen patients. He has had no occasion to change his opinion as reported at that time, although he has since had the opportunity to observe and treat more than thirty such patients. Since the advent of sulfanilamide we have tried it in three cases, but so far as we could determine, it was of no value. We have not tried any other drugs in the sulfonamide group.

It is evident that whatever term is applied to this syndrome, we are dealing with a lymphangitis; even if we look upon it as an erysipelas, histologically it is primarily a disease of the lymphatics. The exact mechanism involved, however, is not so readily determined. McGlasson[4] looked upon it as a streptococcus infection of the lymphatics, a fungous infection by its injury to the skin, furnishing an atrium for infection. Amoss[5] also looked upon it as a streptococcal infection. It must be admitted that the syndrome is most commonly seen on the legs following a siege of dermatomycosis. Traub[6-7] and Sulzberger[8] have been satisfactory results from special attention to treatment of the mycotic infection. The former, therefore, is inclined to look upon it as a trichophytid. The latter, after much theoretical discussion of allergy and immunity, remains undecided as to the mechanism, but evidently also leans to a trichophytid. Juarez[9] and Logefeil[10] want the term "tropical" added, although their cases are exact replicas of our syndrome, and they look upon it as streptococcal lymphangitis.

Our own belief is that the syndrome is always caused by the streptococcus and occasionally by a mixed infection with the staphylococcus. In the past we have had the opportunity to study sections of these cases and were able to find streptococci in the lymphatics much as in erysipelas. While we admit the very frequent association of a fungous infection with this syndrome, we believe that erosions and fissures produced by the mycotic infection simply act as a portal of entry for the streptococcus. This belief is further supported by the frequently complete absence of any clinical evidence of fungous infection of the skin, although these attacks will take place over a period of many years. In fact, it is sometimes difficult to escape the feeling that the pyococcal infection, with its resultant febrile attacks, has altered the immunity mechanism in such a manner as to free the patient from any clinical evidence of the mycosis. Above all, however, we are supported in our theory by the observation of cases in which a fungous infection did not come into question at any time. This very same syndrome may be found on other parts of the body. It is seen not uncommonly on the face, where fissures about the alae nasi and the corners of the lids may act as the atria. Here it is spoken of as solid edema when the changes of fibrosis become sufficiently evident. We have seen a case in which a fissure of the anus has acted as an atrium, another in which the streptococcus was introduced by the sting of a wasp on the back of the neck. One case under our observation was produced by a horse's bite, with injury to the underlying bone; this latter was the only case which resisted all efforts at treatment. It should be noted that, while the term "chronic erysipelas" may not be a misnomer, it is not a true erysipelas in the accepted sense of the term. A change in the patient's immunity has taken place, confining the activity of germs to a restricted area of the lymphatic bed and from there they act much like a focus of infection in the tonsils or teeth. In our observation, acute exacerbations are usually brought about by trauma, exposure, overwork, exhaustion, or improper hygiene.

IN CONCLUSION

A case of recurrent lymphangitis with unusual manifestations is reported. The extensive involvement of the lymphatics and the associated, almost universal dermatitis, with the characteristics of an eczema always appearing and disappearing synchronously with a febrile attack, make it unique in our experience. The subject of recurrent lymphangitis is reviewed and our opinion as to its pathological mechanism is discussed.

1680 Vine Street.

REFERENCES

1. Gans, O.: Histologic der Hautkrankheiten.

2. Wise, F., and Wolf, J.: Dermatophytosis and Dermatophytids, with Particular Reference to Differential Diagnosis of Dyshidrosiform Eruptions of Hands and Feet, Arch. Dermat. and Syph., 34:1-14 (July), 1936.

3. Goeckerman, William H.: Recurrent Lymphangitis, Minnesota Med., 13:902-903 (Dec.), 1930.

4. McGlasson, I. L.: Recurrent Erysipelas of Legs with Dermatitis of Feet, Arch. Dermat. and Syph., 14:679-682 (Dec.), 1926.

5. Amoss, H. L.: Treatment of Recurrent Erysipelas, Ann. Int. Med., 5:500-504 (Oct.), 1931.

6. Traub, E. F.: Dermatophytosis with an Erysipelatous Dermatophytid of the Legs, Arch. Dermat. and Syph., 33:196 (Jan.), 1936.

7. Traub, E. F., and Tolmach, J. A.: Erysipelas-like Eruption Complicating Dermatophytosis, J. A. M. A., 108: 2187-2189 (June 26), 1937.

8. Sulzberger, M. B., Rostenberg, M., Jr., and Goetze, D.: Recurrent Erysipelas-like Manifestations of Legs: Their Relationship to Fungous Infections of Feet, J. A. M. A., 108:2189-2193 (June 26), 1937.

9. Juarez, Jenoro: Clinical Findings in One Hundred Thirty-Nine Cases of Recurrent Tropical Lymphangitis, Puerto Rico J. Pub. Health and Trop. Med., 12:81 (Sept.), 1936.

10. Logefeil, R. C., and Hoffman, R. A.: Recurrent "Tropical" Lymphangitis, with Report of Case, Minnesota Med., 21:479-482 (July), 1938.

CLINICAL NOTES AND CASE REPORTS

INTRAVENOUS THERAPY

DESCRIPTION OF INTRAVENOUS OPERATING TABLE

MALCOLM E. HOFFMAN, M. D.
San Francisco

THE apparatus herein described, and shown in the accompanying illustrations, is an intravenous operating table for use in administering all types of intravenous medication into the antecubital veins.

Its method of operation is as follows: The patient's arm is placed upon the table, with the upper arm in the tourniquet "V" and the wrist secured by the strap. The surgeon then presses down on the foot treadle until the veins are distended, and after cleaning the antecubital space with alcohol, inserts the needle into the vein; he then releases the foot treadle and proceeds to inject the medicament. Thus, with both hands free to manipulate the syringe and needle, the danger of injecting subcutaneously is minimized.

Basically, it is a foot-operated tourniquet that may be raised or lowered for different circumstances, or may be tilted to the proper angle. It can be used at the bedside, in the operating room, or in the office.

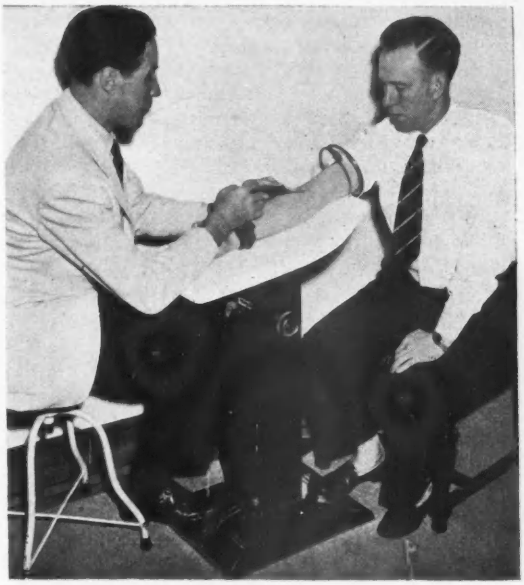

Fig. 1.—Photograph of operating table. Operator has depressed the foot treadle, wrapping tourniquet around the patient's arm. Physician about to insert needle in vein.

It is especially adaptable for giving intravenous anesthesia in that it is often necessary to give repeated doses in long operations.

Also it should prove convenient in luetic clinics

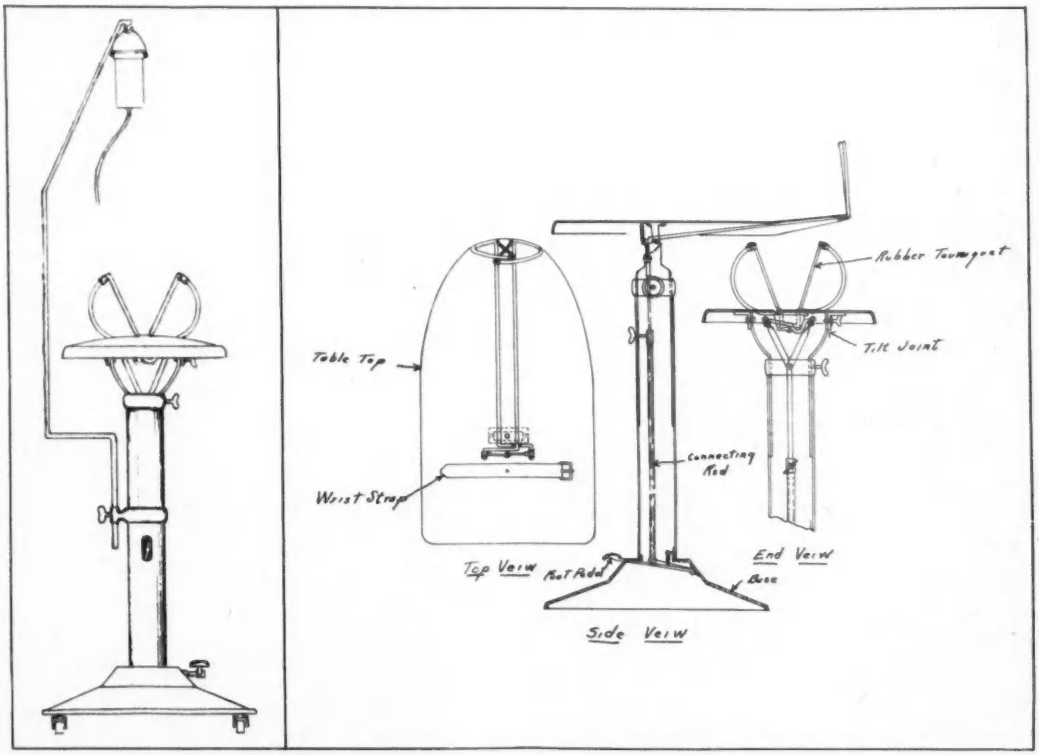

Fig. 2 Fig. 3

Fig. 2.—End view of operating table, showing support for container of saline or glucose solution.
Fig. 3.—Detailed views of operating table, showing working parts.

where large numbers of patients are given intravenous neoarsphenamin daily.

In doing blood transfusions two tables are used, one for the donor and one for the recipinet. The treadle control of the tourniquet around the donor's arm may be regulated so that the arterial blood supply comes through freely at intermittent periods.

At the present time most physicians are doing a great deal of intravenous therapy in their offices and, therefore, can appreciate the table in this routine work.

450 Sutter Street.

HIPPOCRATES' APHORISMS*

Moses Scholtz, M. D.
Arcadia

Section Seven (Continued)

14. Stupor or delirium,
From a blow on the head,
Is a dangerous symptom
To guard against and dread.

15. Blood-spitting leads
To spitting pus,
And oft to a state
Tuberculous.

16. Diarrhea and phthisis
From pus-spit arise;
But, if the sputum stops,
The patient dies.

17. Inflammation of the liver,
Followed by hiccough,
Threatens to carry
The sufferer off.

18. Fits, set upon
A stupor-state,
Forecast an end
Unfortunate.

19. When erysipelas sets in
On a wound of the cranium,
With a bone open and exposed,
The sick is likely to succumb.

20. When gangrene or suppuration
Occur in erysipelas,
Between Scylla and Charybdis
The sick shall have to pass.

21. When a strong pulsation of a wound
Brings on a hemorrhage,
It is a solid indication
That the sickness's in a danger-stage.

22. A protracted pain
Of abdomen,
Followed by pus,
Is a dangerous omen.

23. When dysentery does ensue
Upon unmixed alvine discharges,
Great dangers for the sick accrue.

24. If, in a case of fractured skull,
With an involvement of the brain,
Delirium does intervene,
The treatment's apt to be in vain.

25. Convulsions, following
A severe purge,
Prepare the way
To the patient's dirge.

26. With severe pains
In the abdomen,
Cold extremities
Are a bad omen.

27. Tenesmus during
A pregnant state,
May a miscarriage
Accelerate.

28. A piece of cartilage,
Nerve or bone,
When once cut off,
Can't grow into one.

29. Incipient edema
Is easily controlled,
If heavy diarrhea
Sets in and keeps its hold.

30. With frothy fluxes
In diarrheal cases,
Seep serous exudations
From the cranial spaces.

31. In fever, if the urine throws
A farinaceous sediment,
It is a sign the illness
Will be a long event.

32. When urine flows thin at first,
And bile's precipitated,
An acute type of the disease
Is thereby indicated.

33. If urine is divided in two parts:
A clear one and a thick,
It is an indication
That the man is very sick.

34. When bubbles show in the urine,
The kidneys are in disrepair;
It also carries a suggestion
That 'twill be a long affair.

35. When urine-scum is found
Both fat and copious,
An acute kidney-lesion
Becomes quite obvious.

36. When these symptoms from the kidneys
Merge with spinal muscles-pain,
An abscess forms outward; but with pains inside,
The abscess will inward drain.

413 Longden Avenue.

(To be concluded)

* For other aphorisms, see California and Western Medicine, March 1940, page 125; April 1940, page 179; May 1940, page 231; July 1940, page 35; August 1940, page 85; September 1940, page 130; December 1940, page 272; January 1941, page 27; February 1941, page 82; March 1941, page 124; April 1941, page 229; July 1941, page 35; September 1941, page 140; October 1941, page 204.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HENRY S. ROGERS, M.D.....President
WILLIAM R. MOLONY, SR., M.D.....President-Elect
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JOHN HUNTON.....Executive Secretary

† For complete roster of officers, see advertising pages 2, 4, and 6.

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COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred Ninety-Sixth (296th) Meeting of the Council of the California Medical Association*

Meeting was called to order in the headquarters building of the Los Angeles County Medical Association at Los Angeles, on Sunday, October 26, 1941, at 9:30 a. m.

1. **Roll Call.**

Present: Councilors Henry S. Rogers, William R. Molony, Lowell S. Goin, E. Earl Moody, Elbridge J. Best, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, George D. Maner, Louis A. Packard, Axcel E. Anderson, R. Stanley Kneeshaw, Frank R. Makinson, Frank A. MacDonald, and George H. Kress, Secretary-Treasurer.

Absent: Councilors Harry H. Wilson, Calvert L. Emmons (out of state), John W. Cline, John W. Green (out of state), and Philip K. Gilman, Chairman. (Captain Philip K. Gilman was not able to be present because he was on special Navy duty in Washington, D. C.)

Present by invitation: E. Vincent Askey, Vice-Speaker; John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel; and Mr. Ben Read, Secretary, California Public Health League.

2. **Minutes.**

Minutes of the 295th meeting, held in San Francisco on Sunday, August 10, 1941, were approved. (Abstract was printed in CALIFORNIA AND WESTERN MEDICINE, September, 1941, on page 141.)

3. **Membership.**

(*a*) A report of membership was submitted and placed on file. (Total members who have paid 1941 dues, 6,747; total number of new members in 1941 included in the above, 405; number of 1940 members who have not paid 1941 dues to date, 286.)

(*b*) A list of active members whose 1941 dues were paid subsequent to the last meeting of the Council on August 10, 1941, to number of forty-nine, was submitted. Upon motion duly made and seconded, their active membership for the year 1941 was reëstablished.

(*c*) Upon motion duly made and seconded, it was voted that Minnie A. Seavey, M. D., a member of the Sacramento Society for Medical Improvement, and a retired

*Reports referred to in minutes are on file in the headquarters office of the Association.

member of the California Medical Association, be recommended for affiliate fellowship in the American Medical Association.

(*d*) Executive Secretary Hunton presented a form of *membership card* for possible use in 1942 in lieu of the certificate which has been used during recent years. After discussion, upon motion by Dewey, seconded by MacDonald, it was voted to approve the membership card for 1942.

(*e*) Report was made that Frank McManus, M. D., a retired member, had taken up active membership in the San Mateo County Medical Society.

4. Financial.

(*a*) Financial reports as submitted were accepted and placed on file.

(*b*) Report was made by the special *Committee on Possible Redistribution of Reserve Funds* of the California Medical Association (references: minutes of August 10th Council meeting, September, 1941, CALIFORNIA AND WESTERN MEDICINE, page 142, item 4 (b)). It was voted that the submitted recommendations to distribute certain funds among a group of banks listed be approved.

(*c*) Statements for legal services rendered in connection with certain work having to do with the protection of the interests of scientific medicine were presented. After discussion, it was voted that the bills submitted be paid.

(*d*) A letter dated October 20th, received from the *California Academy of Medicine,* was presented, relative to participation by the California Medical Association in the payment of part of an honorarium to a guest speaker who would be available for a limited number of appearances before county medical societies.

It was stated that the Committee on Postgraduate Activities of the State Association felt that its budget would not permit participation in the proposed plan. The decision of the Postgraduate Committee was concurred in by the Council.

5. County Society: Request for a Duplicate Charter.

The Stanislaus County Medical Society having lost its charter, and a request having been made that a duplicate be issued, the State Association Secretary was instructed to secure additional information from the Society.

6. Committee on Public Health Education.

(*a*) *Exhibits at State and County Fairs.*—The Committee on Public Health Education made report through its chairman, Frank R. Makinson. Concerning public health exhibits at state and county fairs, Doctor Makinson commented on the value of state and county fairs as excellent media for the dissemination of knowledge concerning the activities of scientific medicine in relation to public health.

On motion by Makinson, seconded by Powell, it was voted that, until otherwise ordered by the Council, the interest of the Herzstein Bequest Fund be earmarked for use in measures designed to combat quackery, by promotion of public health exhibits in county fairs, through purchase of necessary display and film equipment, transportation and care of equipment, transportation and cost of authorized attendants, and other means sanctioned by the Council or Executive Committee.

(*b*) *Basic Science Initiative.*—Report was made by Councilor Makinson concerning the costs involved to date, in connection with the printing and circularization of the petitions designed to place a basic science initiative on the ballot of the next state election. In the discussion which followed, it was brought out that petitions containing a total of some 39,000 names were on file. These petitions contained the names of 25,000 citizens residing in the southern section of California, the remaining 14,000 names being of citizens residing in the northern section of the state.

Statement was made that, in order to put the initiative petition across in good form, experience has shown that at least 150,000 signatures should be secured from Los Angeles County. The average number of names on petitions thus far received was sixty-three.

It is planned to make a check of component county societies about November 15, and about the same time to request the coöperation of the members of the Woman's Auxiliary to the California Medical Association. It was pointed out that a total of about 300,000 signatures would be necessary to insure the 212,000 valid signatures needed; and that if this number is not secured through the medical profession and affiliated organizations, it will be necessary later to employ commercial circulators, at an expense of something like ten cents per name.

The importance of observing the rules in regard to petitions was pointed out. In each county, the County Clerk or the Registrar of Voters has the authority to determine the validity of petitions presented.

Upon motion duly made and seconded, it was voted that the sum of $2,000 be allocated from the General Fund to cover contemplated expenditures.

7. California and Western Medicine.

(*a*) *New Printer for the Official Journal.*—Report was made by Executive Secretary Hunton that on and after January 1, 1942, CALIFORNIA AND WESTERN MEDICINE would be printed in Los Angeles instead of San Francisco (Wolfer Printing Company, Inc.), this action being taken in accordance with authority granted by the Council at its 294th meeting (item 8, on page 38 of the July CALIFORNIA AND WESTERN MEDICINE) and at the 295th meeting (item 19, on page 144 of the September issue).

Letters from The James H. Barry Company, present printers of CALIFORNIA AND WESTERN MEDICINE, were presented and ordered placed in the files.

Announcement was made that an advertising representative for the southern section of the State had been engaged.

(*b*) The resignation of Packard Thurber, M. D., one of the members representing industrial medicine and surgery on the editorial board, was received and accepted. Dr. John D. Gillis of Los Angeles was elected to fill the vacancy.

8. Recess—Executive Committee Meeting.

At this point a recess was called to permit the Executive Committee of the California Medical Association to hold a meeting.

9. Medical Services Rendered by Hospitalization Groups.

(a) The *scope of medical services rendered by hospitalization groups and organizations* came up for discussion. (References: House of Delegates Resolution 14, June CALIFORNIA AND WESTERN MEDICINE, page 340; Council minutes, September CALIFORNIA AND WESTERN MEDICINE, item 7, page 142).

(b) *"Statement of Association Policy."*—Correspondence with representatives of the Pacific Roentgen Society was presented. After discussion, upon motion by Goin, seconded by Anderson, it was voted that the following restatement of policy of the California Medical Association in relation to medical services involved in hospitalization plans be made a matter of record, this statement being as follows:

HOSPITAL SERVICE INSURANCE

A Statement of Policy Issued by the California Medical Association, October 26, 1941

The California Medical Association has consistently endorsed the principle of hospital service insurance and, upon request, the Council of the California Medical Association has given its approval to some or all of the activities of local hospitalization associations. The California Medical Association recommends only those hospital contracts which provide straight hospital services. It does not give and it never has given approval to any contracts which provide

medical benefits or services as a part of hospital services. It does not object to the provisions of limited diagnostic medical services (x-ray and laboratory) along with hospital benefits, provided that these are arranged for on some ethical and legal basis such as reimbursement or indemnification. The following points are, therefore, emphasized:

1. The California Medical Association approves hospital service insurance associations which issue straight hospital service policies (for example, the hospital contract issued by Hospital Service of California and the Associated Hospital Service of Southern California in conjunction with California Physicians' Service).

2. It does not recommend any hospitalization contract which provides diagnostic x-ray, laboratory or other medical services as hospital benefits. These are medical benefits and may only be issued on an indemnification or medical service basis.

3. When hospital service insurance associations issue hospital service contracts which include indemnification for diagnostic medical services, it is desirable that such be specified in the description of the contract (for example: Hospital service contract and limited professional service contract). Further, it is desirable that the association issuing such contracts make specific arrangements whereby the fees for radiology or pathology are payable to the physician rendering those services, or jointly to the physician and subscriber (in which case the subscriber can endorse the check over to the physician rendering the service). In this manner the hospitalization association will be complying with the letter as well as the spirit of indemnification.

4. The California Medical Association emphasizes that it does not approve or endorse any hospital service contracts which purport to provide any medical services as a part of hospital services, nor can it countenance the issuance by any hospitalization association of advertising literature which does not indicate that payment for medical services is being made to physicians rendering such services. It is important for the welfare of the public, the hospitals, and the medical profession that a clear distinction be made between hospital service and medical service in any and all of these hospitalization insurance contracts.

(c) *Schedule of X-Ray Charges for Selective Service Work.*—Correspondence between Dr. L. Henry Garland, for the Pacific Roentgen Society and General J. O Donovan, State Director of Selective Service for California was presented concerning schedules of costs for x-ray charges, the same being attached to a letter dated October 9.

After discussion, upon motion by Goin, seconded by Kneeshaw, it was voted that the schedule of charges for x-ray work, as submitted, be approved.

(d) *Charges for Electrocardiograms.*—Discussion was had concerning an equitable charge for electrocardiograms, the opinions of some cardiologists being submitted. It was voted that this subject be further investigated, and after adequate information has been received from members of the profession who are directly interested, the Chairman of the Executive Committee be empowered to transmit recommendations to the State Director of Selective Service.

(e) *Charges for X-Ray Work, in Relation to California Industrial Commission.*—A communication having date of October 16, received from Dr. L. Henry Garland in re industrial accident fee schedules, was read. After discussion, upon motion by Makinson, seconded by Anderson, it was voted that further investigation be made and when adequate information has been secured the Executive Committee be empowered to act and to transmit its recommendations to the Commission. It was agreed that the Council Chairman should promptly contact members of the Special Committee on Insurance Fee Schedules (Doctors Morton R. Gibbons, Sr., San Francisco; Carl Hoag, San Francisco; and Frank A. MacDonald, Sacramento) in regard to the issues involved.

10. Survey of California Medical Association Legal Department.

(a) The Special Committee to Survey the Legal Department of the California Medical Association (Doctors Philip K. Gilman, San Francisco; Henry S. Rogers, Petaluma; Frank R. Makinson, Oakland; and Elbridge J. Best, San Francisco) submitted a progress report through Acting Chairman Elbridge J. Best. On motion by Anderson, seconded by Moody, same was received and placed on file.

11. California State Compensation Insurance Fund: Some Testimonial Correspondence.

(a) *Presentation of Copies of Certain Letters and Action Taken Thereon.*—The attention of the Council was called to certain communications that had been circularized to members of the medical profession by the Wilshire Medical Laboratories of Los Angeles, as follows:

1. A photostatic copy of a letter bearing the signature of John C. Stirrat, Manager of the State Compensation Insurance Fund; and

2. An appeal that laboratory work needed for injured employees be sent to said laboratory.

After consideration of the same and other evidence, upon motion duly made and seconded, it was voted that the Council agreed that the manager of the State Compensation Insurance Fund has exhibited unwarranted favoritism in favor of said laboratory, thus discriminating against many equally or better qualified laboratories.

Further, the Council of the California Medical Association considers compliance with the suggestions contained in the photostatic copy of the letter dated August 22, 1941, and signed by the manager of the State Compensation Insurance Fund, to be beneath the dignity of the members of the California Medical Association.

The Council also expresses its unqualified disapproval of this campaign of solicitation by a state official on behalf of a private institution, ignoring as he has done, many competent, medically directed laboratories in Los Angeles and vicinity, in addition to the attempted use of political influence in relation to the medical care of the unfortunate victims of industrial accidents.

(b) *Instructions to Executive Committee to Call Attention of Certain State Officials to Pertinent Correspondence.*—After further discussion, on motion duly made and seconded, it was voted that the Executive Committee be directed by the Council, within fourteen days, to formulate a protest embodying the sentiments included in the aforesaid resolutions, and as brought out in the discussion on the evidence presented; and that copies of such protest be forwarded to His Excellency Governor Culbert Olson, Mr. John C. Stirrat, Manager of the State Compensation Insurance Fund, the Industrial Accident Commission, the State Compensation Insurance Fund, and other interested state agencies, such protest to have attached, copies of the photostat letters bearing the signature of Mr. Stirrat, and the two enclosures from the Wilshire Medical Laboratories; and, further, that the action taken by the Council be published in the editorial section of the next issue of California and Western Medicine.

12. Committee on Needy Members (Medical Benevolence.

(a) The special Committee on Needy Members (Drs. A. E. Anderson, chairman; Elizabeth Hohl, and Robert A. Peers), presented a progress report on plans whereby this new activity of the California Medical Association could be instituted to best advantage. Discussion was had concerning various means of conserving and increasing the fund which, by action of the House of Delegates at Del Monte in May, 1941, through the allocation of $1 from the State dues of each member, was brought into being. Considerable discussion took place concerning different forms of insurance annuities. It was agreed that this fund was in the nature of a trust and that before expenditures could be made therefrom it was most important that a proper financial set-up should be put into operation in the headquarters office. The suggestion was made that the Executive Secretary, upon whom would fall the special responsibility of executing financial instructions concerning the fund, should draft a plan of procedure, the same to be submitted to the Committee on Needy Members; and by that committee to be presented with other recommendations at the next meeting of the Council, at which time

it was hoped to place the fund in active operation. Upon motion by Packard, seconded by Moody, it was so voted.

13. Industrial Accident Commission Ruling 19 of Date of September 16, 1941.

(*a*) The recent ruling of the Industrial Accident Commission of the State of California (Reference: October CALIFORNIA AND WESTERN MEDICINE, page 171), was called to the attention of the Council through a letter dated October 13, 1941, received from Dr. Nelson J. Howard of San Francisco, in which criticism was made of the possible increase in paper work which might be demanded of physicians who are doing industrial work. Since the entire subject is still under consideration, the Council took no action.

14. County Society Committees on Medical Defense.

(*a*) A letter from the Chairman of the Association's standing Committee on Medical Defense, Dr. Nelson J. Howard, and dated October 13, 1941, was presented. The Committee called the Council's attention to the work it had been carrying on in efforts to induce component county societies to adopt suggestions concerning local Grievance Committees and other recommendations, and through which it was hoped a certain number of unwarranted malpractice suits might be prevented. The Committee requested the Council's approval of its action in asking such coöperation from the component county societies. Upon motion by MacDonald, seconded by Dewey, the Council voted such approval.

15. Concerning Pasteurization of All Milk.

(*a*) A progress report was made concerning the expressions of opinions received in questionnaire replies from the representatives of Certified Milk Commissions, regarding the need or desirability of pasteurizing all milk, inclusive of certified milk. (Reference: Item 30 of Council meeting of August 10, 1941.) This subject having been called to the attention of the Council by Doctor Emmons, who was absent, it was felt that the matter could be held over for consideration at the next Council meeting.

16. Legal Department: Reports.

General Counsel Hartley F. Peart reported on the following matters:

(a) *Survey of a County Hospital.*—The Council's attention was called to certain court actions in one of the California counties, in which some issues were involved of importance to the best interests of the public health, and of the advancement of scientific medicine.

(b) *Business and Professions Code: Reciprocity Amendment.*—Mr. Peart placed before the Council correspondence dealing with a possible attack on the constitutionality of this recent amendment to the Code.

(c) *Intercoast Hospitalization Insurance Association.*—A letter from Mr. D. B. Frantz, counsel for the Intercoast Association, was read requesting a ruling regarding payment for professional services in the administration of anesthetics. The Legal Counsel was authorized and directed to forward to Mr. Frantz a statement of the policy of the Association with reference to this matter this day adopted and to give a specific answer to the question presented, the letter and contents to be approved by the Chairman of the Council.

(d) *Retired Membership: Leaves of Absence.*—The General Counsel read his opinion to the Association, dated September 19, 1941, setting forth the conditions under which retired membership is now granted by county societies, this Association, and the American Medical Association. The report was ordered filed.

Questions of leaves of absence by county societies were also submitted. Legal Counsel will submit to the Council drafts of appropriate amendments.

(e) *Industrial Accident Commission: Rule Concerning Medical Records.*—Mr. Peart read his opinion to the Association, dated September 24, 1941, and discussed certain phases of the rule in response to questions of various members of the Council.

(f) *Social Security Taxes—Old Age Taxes.*—A report was presented covering old age taxes paid on demand of the Commissioner of Internal Revenue ruling holding that the Association was entitled to exemption. Refund claim for $468.01 was denied November 1, 1939. Mr. Peart pointed out that suit must be commenced before November 20, 1941. Mr. Peart advised that, in view of recent decisions upholding the right of the Government to set aside an existing exemption, it would be inadvisable to sue.

On motion duly made, seconded and unanimously carried, the report of the attorney was approved and he was instructed not to commence action on this refund claim.

(g) *Unemployment Taxes.*—The Counsel then reported that the unemployment tax for the years 1936-1939 involved the sum of $1,266.06, for which refund claim was rejected August 31, 1940; that the Association had until August 30, 1942, within which to commence an action to recover these taxes; that the point involved in this matter was whether or not the councilors and officers of the Association were employees within the meaning of the Act, thereby bringing the total of the employees above eight for these years; that two District Court decisions had held that such unpaid officers were not employees and one District Court had held that unpaid officers were employees, and that action should, therefore, be deferred to await further court decisions.

On motion duly made, seconded and unanimously carried, the Legal Counsel's report was approved.

(h) *Tulare Community Hospital.*—The Legal Counsel called the attention of the Council to a projected community hospital at Tulare, Tulare County, California, and the request of members of the Association in that city for assistance in the organization of the hospital.

(i) *Federal Tax on Membership Dues.*—Mr. Peart read a copy of his opinion to Mr. John Hunton, Executive Secretary of the Association, dated October 16, 1941, advising that the recent amendments to the Internal Revenue Code do not change the law or impose a tax on admissions and dues of the members.

(j) *Malpractice.*—A brief report on events occurring in a component county medical society in connection with a malpractice action was submitted.

17. Date of Next Meeting of California Medical Association Council.

(*a*) The Association Secretary asked for instructions concerning the date of the *next meeting of the Council*, stating that, in accordance with past custom, the same could be a two-day session; one day being given over to a *meeting of the county secretaries*, and the other day to the Council meeting.

It was thought that Sunday might be a more convenient meeting day for many county society secretaries, especially since other county society officers also might find it then to be convenient to attend.

(*b*) It was agreed that the meeting on Saturday should be a Council meeting and that the meeting on Sunday, immediately succeeding, should be designated for the joint conference of county society secretaries and State Association officers and committees. The third week in January was suggested as a possible time. Upon motion duly made and seconded, the final decision as to date of the meeting was left to the Chairman of the Council.

18. Progress Reports of Special Committees.

(*a*) A progress report was submitted by the special *Committee on Pension Policies for Employees* (Edward N. Ewer (chairman), Junius B. Harris, Edward M. Pallette, Sr.), and it was stated therein that the entire subject

was still being studied. The progress report was received and placed on file.

(*b*) The *Committee on Hospitalization Subsidy* (John H. Shephard (chairman), Wayne E. Pollock, Neil J. Dau), made a progress report concerning the work it had carried on to date. This report was received and placed on file.

19. **Evacuation and Other Plans for the Southwest Border of the United States.**

(*a*) Attention was called by McClendon to the plans which had been formulated by authorities of Arizona, Mexico, New Mexico, and California, concerning the best means of caring for citizens living along the border lines of the states involved, in case certain international emergencies arose. Upon motion by McClendon, seconded by Packard, it was voted that the general plan to which the Arizona State Medical Society had already given approval, also receive the sanction of the Council of the California Medical Association, and that the chairman of the Special Coördinating Committee, Dr. Francis E. Toomey of San Diego be so notified.

20. **Proposed Codification of Code of Ethics.**

(*a*) The desirability of having a codification of rulings which had been handed down concerning the Principles of Ethics of the American Medical Association—which is also the Code of Ethics of the California Medical Association—was called to the attention of the Council by McClendon. After discussion of the different phases of the subject, upon motion by Packard, seconded by Kneeshaw, it was voted that the Chairman of the Council appoint a committee of three or five members to make a study of the subject, with instructions to bring in a report and recommendations to the Council, for subsequent consideration by the House of Delegates at the next annual session; the scope of such a report to take into consideration not only codification but interpretation of various ethical principles.

21. **California Youth Correction Authority.**

(*a*) The California Youth Correction Authority enacted at this year's session of the legislature, and now comprising Chapter I, Sections 1700-1783 of the Welfare Institution Code, was informally discussed by Rogers. President Rogers stated that an organization meeting of the State Panel on Nominations, of which the President of the California Medical Association is one, would be held on Monday, October 27, 1941, at which time he would call the attention of the four other members of the committee to the desirability of having at least one of the three members of the Authority be a physician, with a background to indicate his capacity to be of special service in the supervision of "preventive and corrective training and treatment for persons under twenty-three years of age, who at the time of apprehension were committed to municipal or superior courts."

22. **Committee on Public Policy and Legislation.**

Chairman Dwight Murray, not being present, the attention of the Council was called to some recommendations made by him:

(*a*) It was suggested that the *California State Federation of Labor* be contacted to learn what was the status of the proposed plan of that organization in re panels of physicians who are called upon to care for injuries and diseases coming under the jurisdiction of the Industrial Accident Commission. It was suggested that conferences with other interested groups were also desirable. The Chairman of the Council was requested to confer promptly with the special committee that was making a study of this problem (John W. Cline (chairman), Morton R. Gibbons, Sr., Nelson J. Howard, R. Stanley Kneeshaw, and John W. Green), in order to secure early action thereon.

(*b*) Chairman Murray called the attention of the medical profession of the state to the generous *coöperation which had been rendered by legislators* in the promotion of statutes designed to promote the best interests of public health and of scientific medicine, expressing the hope that physicians everywhere would feel free to thank their legislative representatives for the aid that had been so rendered, and to extend all possible courtesies.

(*c*) Attention was called to the *new law* (Reference: Chapter 573; Assembly Bill 690), *granting special traffic privileges to physicians* who were on emergency calls. Report was made on the design that had been drafted by the California Department of Motor Vehicles and which that state department had the authority to adopt. Attention was also called to the desirability of certain amendments to the recently enacted law designed to better safeguard the integrity and use of the emblem.

23. **Rehabilitation Plans for Draftees Under the Selective Service Act.**

(*a*) Attention was called to the proper interpretation of the statistics on so-called "physical defects" that were stated to be responsible for a large number of selectees being declared unfit for military service. It was felt that the widespread publicity concerning these figures—exploited as they were, without proper explanatory comment on why they existed, and outlines of rational ways and means whereby such deficiencies could be best eradicated—would lead many citizens to draw erroneous impressions concerning medical service standards. It was suggested that the Committee on Public Health Education and members of the profession, through the county medical societies, give this subject their early attention, and that proper publicity of the basic causes be promoted. In the discussion it was pointed out that the proposed rehabilitation program might be used by some, as a reason for the instituting of a compulsory health insurance system.

24. **Association of Military Surgeons.**

(*a*) The President of the Association was authorized to send a telegram to the Association of Military Surgeons in session at Louisville, suggesting that the next annual meeting of that organization be held in California.

25. **Adjournment.**

(*a*) Upon motion duly made and seconded, it was voted to adjourn. The adjournment was ordered made in memory of the late Dr. Howard Morrow, president of the California Medical Association in 1938, whose death occurred on Wednesday, October 22, 1941.

ELBRIDGE J. BEST, *Vice-Chairman.*
GEORGE H. KRESS, *Secretary.*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Selective Service Physicians Will Continue to Serve

The announcement made under Medical Preparedness in *The Journal*, October 18, page 1364, that a single physical examination for selective service registrants would be the procedure to be followed after January 1, 1942, was based on an official release from the National Headquarters of the Selective Service System. Subsequently, an announcement has been received to the effect that this origi-

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

nal release was premature and that a further statement will be made in the near future indicating the modifications that are to take place in the methods of examination.—*The Journal of the American Medical Association*, October 25, 1941.

* * *

Plans for Rehabilitation of Rejected Draftees*

In his press conference, October 10, President Roosevelt criticized the nation for permitting conditions which have left 50 per cent of its youth unfit mentally or physically for Army service, and inaugurated a program to "salvage" 200,000 of the 1,000,000 youths who have been rejected.

Under the salvage program the Federal Government will pay medical costs for treatment by local physicians of approximately 200,000 registrants whom local draft boards certify as susceptible of rehabilitation for Army service. The Army expects to accept virtually all of these 200,000 after they undergo treatment by family physicians or dentists at federal expense, Mr. Roosevelt said.

Describing the salvage program as only the initial objective, Mr. Roosevelt said that existence of conditions which permit so high a ratio of rejections is an indictment of America. He said he would launch a long-range program calling for coöperation of states, counties, cities, townships, and individuals to remedy the conditions which are the underlying cause of the bad situation. He released statistics collected by Selective Service Headquarters showing that approximately 1,000,000 men have been disqualified for Army service because of physical, mental, or educational conditions. This represents approximately 50 per cent of the total number of men examined. Mr. Roosevelt made it clear that he feared this ratio among men of draft age represented a fair index of the health conditions of all Americans.

The President read from a report presented by Brigadier General Lewis B. Hershey, Selective Service director, which declared that, of the 1,000,000 rejected, "about 200,000 can be completely rehabilitated and made available for general service in our armed forces. The remainder can be rehabilitated to perform only limited service or, because of mental, nervous, cardiovascular and pulmonary diseases and musculoskeletal defects are incapable of rehabilitation or even limited service and are, therefore, not being considered under the present rehabilitation program for Selective Service registrants," Hershey's report said.

"Our initial objective in this rehabilitation program will be the 200,000 registrants who can be completely rehabilitated and made available for general military service in the armed forces at a small cost and in a reasonably short time.

"Certain types of venereal diseases, operable hernias, deficiencies in vision and teeth, and other minor defects will be corrected in cases where the Army determines that the registrant will then be acceptable for general military service.

"The registrant will have the privilege of having the services performed by his family physician or dentist in his own community.

"The cost of this rehabilitation program will be borne by the Federal Government as a necessary part of our national defense program, and additional funds will be made available to the Selective Service System for this purpose."

Mr. Roosevelt was asked by what authority registrants could be compelled to undergo medical or dental treatment to prepare themselves physically for military service. He replied that when a registrant appears before an examining board he is under the jurisdiction of that board and can be directed to undergo such treatment. Conjecturing that a majority of such persons would be willing and eager to receive free treatment, Mr. Roosevelt said that in cases of recalcitrancy the registrant could be inducted into the Army, placed under Army orders and commanded to undergo treatment. The President disclosed that the Army also had presented an alternative program, which he rejected, calling for induction of all rehabilitable cases and their treatment in Army medical centers.

When costs of housing, food, clothing, Army pay and medical care in this program were considered, Mr. Roosevelt said it would involve expenditure of approximately $500,000,000. The salvage program by local physicians and dentists which he has approved will cost far less than that, he said.

The President disclosed that plans already are well advanced for the salvage program. In cases of heart and musculoskeletal diseases, as well as mental and nervous cases, persons considered by local boards as being susceptible to rehabilitation will be placed in a special selective service category. Remaining under orders of their selection boards, these men will be visited by traveling boards or "teams" of prominent specialists, who will examine them and recommend curable cases for immediate treatment at Government cost.

The Selective Service report itemized as causes for rejection:

Dental defects, 188,000 cases, 20.9 per cent.
Defective eyes, 123,000 cases, 13.7 per cent.
Cardiovascular diseases, 96,000 cases, 10.6 per cent.
Musculoskeletal defects, 61,000 cases, 6.8 per cent.
Venereal diseases, 57,000 cases, 6.3 per cent.
Mental and nervous diseases, 57,000 cases, 6.3 per cent.
Hernia, 56,000 cases, 6.2 per cent.
Defects of ears, 41,000 cases, 4.6 per cent.
Defects of feet, 36,000 cases, 4.0 per cent.
Defective lungs, including tuberculosis, 26,000 cases, 2.9 per cent.
Miscellaneous, 159,000 cases, 17.7 per cent.

The President said that in the cases of dental defects, hernias, eye trouble, and even cardiac and musculoskeletal defects, the ratio of cures is expected to be relatively high. Venereal cases are especially susceptible of salvage, he said, and venereal-infected registrants will be kept under the orders of selection boards and instructed to get themselves cured quickly and report back for service. The salvage program, Mr. Roosevelt admitted, leaves for future consideration the larger question of why half of American youths are physically and mentally defective and why 100,000 had to be rejected because of a lack of a fourth-grade education.

Colonel Leonard G. Rowntree, chief of the Selective Service Medical Division, after a conference with the President, said that the preliminary figures point to the inescapable conclusion that there is an urgent need for a national campaign for improvement of general health.—*The Journal of the American Medical Association*, October 18, 1941.

* * *

Rehabilitation of the Draftees

At his press conference on October 10 the President of the United States indicated a plan for rehabilitation of the draftees who are classified at the time of their first physical examination as being susceptible of rehabilitation at a reasonable cost in a comparatively short time. Estimates publicly announced by different agencies have indicated that the number susceptible of rehabilitation varied from 20 to 50 per cent of those rejected as unfit. As indicated in the item published under the heading of Medical Preparedness in the current issue of *The Journal*, the President apparently accepted the more scientific estimates submitted to him; he indicated that approximately 200,000 men would be susceptible of rehabilitation for military service.

No doubt the large majority of those susceptible of rehabilitation represent draftees whose difficulties are concerned with the teeth. Thus, much of the burden of rehabilitation will fall on the dental profession. Apparently representatives of the press who interviewed the President were doubtful about the possibility that draftees would volunteer for rehabilitation or that they could, under some type of legal ruling, be compelled to undergo necessary rehabilitation. The President, however, seems to have had legal opinions as to how such rehabilitation might be compelled, once the draftee came under the control of his Selective Service board. . . .—Editorial in *The Journal of the American Medical Association*, October 18, 1941.

* For editorial comment, see page 226.

Concerning Physical Defects of Selectees

In the *Press Democrat* of Santa Rosa, issue of October 24, 1941, Dr. W. C. Shipley, a member of the Sonoma County Medical Society, has an article concerning the experience of the local Board of Medical Examiners of selectees, to which he has attached his observations concerning the nature of some of the physical defects and their causes.

Because so much misunderstanding has arisen concerning the background of physical defects that interfere with a man's "military fitness" as contrasted with "utilitarian fitness," the following excerpts from Doctor Shipley's article are presented in this column:

The greatest trouble is poor teeth, insufficient natural teeth and in some cases no teeth at all.

Heart and blood vessels come next, along with high blood pressure, poor eyesight, defective hearing or diseased ears, hernias, hemorrhoids, varicose veins, bodily deformities, underweight, overweight, kidney disease, diabetes, congenital defects, disturbances of the endocrine glands—especially the thyroid and pituitary—mental subnormals neurotic, etc., all contribute a share in the unfortunate picture.

Very few have been found tubercular and less than two per cent are afflicted with syphilis and about the same number with other sex diseases.

Of the overweights a few are due to supernutrition, but the bulk are caused by glandular disturbances or imbalance.

The underweights are all the result of malnutrition; in other words, improper food and a desire to burn the candle at both ends.

Three have been found who could not read or write sufficiently to be able to make out their own papers, as they had only a few months' schooling; yet all three were born and reared in California.

Now as to the causes of these defects—bad teeth, poor postures, underweight—some skeletal defects are due to lack of proper food, malnutrition, and lack of medical, dental and parental care in infancy and childhood.

Too Much Trash

Too much trash—candy, lollypops, soft drinks, soda-fountain goos and highly refined, premasticated and predigested foods devoid of vitamins which give the whole digestive system, from the mouth all the way through the body, little or no work to do, and as a result the whole bodily functions get lazy and fall down on the job of building a perfect human being.

Some of the heart-trouble cases were born that way, some result from infections such as rheumatism, pneumonia, diphtheria, or infected tonsils.

Quite a number result from overstrain and excessive competitive athletics in school—they are forced to their utmost, to do or die for their dear old alma mater, with a desire to make stars of themselves and a great record for their school—all to the physical detriment of a growing and still plastic body.

Blames Athletics, Cigarettes

Intensive competitive athletics are a definite cause of heart trouble, flat feet, damaged bones, joints, muscles and tendons, as well as some other body organs.

Excessive use of cigarettes are also a fruitful source of heart, lung, and nervous system misfortunes. Some very few can trace their trouble to excessive use of alcohol.

We have found none suffering from overwork, for most people when they do work seldom overtax their bodies.

Late and irregular hours in the formative period of life add their share to the cause of deficiencies in later life and so the picture of physical unfitness in this great and glorious land of ours, the country with the highest standard of living in all the world, with about half its young men unfit for military service, is not one of beauty or to be proud over.

The correction of these defectives, or rather their prevention in future generations, is a gigantic task and, like the labors of Hercules, will prove to be a task greater than one man can solve, but a few suggestions might not be out of order.

Children and those in their early teens should have regular hours, go to bed early, rise early, have plenty of outdoor exercise, a properly balanced diet which requires chewing, without a flock of trashy foods, bubbly drinks, knicknacks, fancy dishes, along with proper exercise and periods of rest.

If we all followed that Biblical injunction, "Be ye temperate in all things," it would redound to our physical, mental, moral, and social well-being.

Of course, many of those now unfit are beyond complete repair; many could be restored to a fair condition of physical fitness by medical, surgical, and dental care.

Must Look to Future

Our greatest job will be the prevention of these sad conditions in the boys and girls to come in future generations.

We compel our youth to attend school and get an education. Now, a healthy body is as important or even more so to national welfare than an educated mind; so it would seem proper medical and dental care from infancy to adult life and on to its end, with proper diet and reasonable physical training, with regular physical examinations at stated intervals so that any beginning trouble may be discovered and checked before it gets the upper hand, is the basis upon which to build a mentally and physically nearly perfect population. . . .

* * *

One Physical Selectee Quiz Is New Plan

From an October 8 dispatch, dated Washington:

In an apparent effort to meet a major criticism of the draft program, selective service officials said today that by January 1, draftees will be required to undergo only one physical examination for induction into the army.

At present, draftees are examined by selective service physicians attached to their local boards and then must be reëxamined by army doctors before being accepted for service. In many cases, men have given up their jobs and sold their belongings only to fail the army's medical examination.

Under the new plan, draft officials said, the registrants would know "almost for a certainty" that if they pass the single examination by army doctors, they will be inducted into the armed forces. The new program also will relieve in part the burden on thousands of private doctors who have been conducting the examinations at local draft boards on a voluntary basis.

The new plan calls for each state to be divided into districts, with army physicians conducting examination of selectees in each. In the more congested areas, examination stations will be established on a full time basis while in sparsely settled areas, the tests will be given at stated intervals. Whenever possible, the draftees will be permitted to return to their homes on the same day they are examined so as to disrupt their private affairs as little as possible.

Army corps area commanders have been instructed by the war department to expedite the program but it probably will not be in operation throughout the country until next January 1.

* * *

We Salvage Aluminum Pots; Why Not Men?

The draft has already shown a million young Americans physically or mentally unfit to carry a gun, or lacking the most rudimentary education. This would be appalling if it were beyond correction, a handicap on defense, a mortgage on society in pursuits of peace.

The Chronicle, at the start of the draft, urged that the opportunity to raise the physical standards that obviously would be presented by draft examination results, be used as soon as it might be done without interrupting the immediate necessities. That time, Mr. Roosevelt believes, is at hand and he proposes a salvage program for this human material.

Of the million rejected, Mr. Roosevelt says reports show that about 200,000, or one in five, can be readily brought to par. Some 100,000 are without the equivalent of a fourth grade education, but are physically fit and mentally alert. Most of the remaining 700,000 can be fitted for limited service. There are some, of course, beyond reach of correction. But these are not a problem of rehabilitation, some are beyond it, others are not necessarily social liabilities if we remember that Beethoven and Edison were deaf, Milton was blind, Van Gogh minus an ear, Steinmetz a hunchback.

The method and cost of salvaging the million, and others as disclosed, are to be considered. The best method, Mr.

Roosevelt believes, is to let the individuals select their own doctors and dentists. If they have no choice, professional service may be assigned through draft authorities. The cost, Mr. Roosevelt has not attempted to estimate at this time. To induct the 200,000 and treat them under Army supervision he says has been estimated as high as $500,000,000.

If the sole purpose were to obtain the fittest material at the cheapest possible price, it might be coldly practical to say the Government should take the best and let the rest shift for themselves. But they are part of the Nation that the best are called upon to defend. From the social viewpoint there also is a practical issue. The cost may be, must be, balanced against the value of military service, full or limited, of a million young men and also their peacetime value compared with what it may be if their defects are neglected. Their condition will not be static.—Editorial, from San Francisco *Chronicle*, October 11.

* * *

On "Utilitarian Efficiency": California Youth Administration

At least 80 per cent of California youth between the ages of 17 and 25 are in "utilitarian" physical condition, it was estimated this week by Robert Wayne Burns, State National Youth Administrator, on the basis of 10,910 complete physical examinations conducted within recent months by NYA employed physicians under the direction of Lowne W. Bell, NYA State Health Supervisor, and Dr. Wilfred Halverson, NYA Health Consultant and Los Angeles County Health Officer.

"Utilitarian," Burns explained, "means that youths may safely be assigned to practically any type of work appropriate to their sex."

The estimate was formulated on the factual basis of a detailed breakdown of the 1,928 examinations given in July. Of these, 420 or 21.8 per cent, were free from any defect; 897, 46.5 per cent, had slight correctible defects of teeth, vision, etc.; 448, 23.2 per cent, had slight permanent defects, not serious in nature; 110 youths were definitely handicapped physically; 51 were temporarily unemployable and only 2 were permanently unemployable.

On the basis of the July examinations, 91.5 per cent of the youths examined were physically able to undertake practically any type of work.

Since the total of 10,910 examinations have been of youths living in the same areas and under similar conditions to the youths examined for the July breakdown, Burns pointed out that 80 per cent would be a safe, conservative estimate of the percentage of physical fitness among the youth of the State.

He stated his belief that the 10,910 examinations represent an accurate cross-section of California's youth population. . . .

Burns stated that NYA is referring youths with ailments to physicians for treatment as fast as its restricted referral facilities will permit. NYA employed physicians do not give treatment, themselves, except at resident projects but merely examine the youths and urge them to remedy health defects through treatment by local physicians.

Health conditions at NYA resident projects, of which there are twelve throughout the State, were announced as excellent. Out of a total of 36,295 youth-worker days in July, only 570 were lost from sickness—about 1.5 per cent.

* * *

500,000 Women to Be Taught Home Nursing

Project Undertaken by Red Cross as Civil Defense Measure

Nation-wide expansion of American Red Cross classes in home nursing to reach 500,000 American housewives in the next year was announced in Washington by Chairman Davis. . . .

The new goal, six times the number trained last year, will require 15,000 registered Red Cross nurse instructors, Chairman Davis reported. Last year 2,500 nurses, many volunteering their time, taught 80,000 women and girls.

The women receiving this instruction, he said, will form a vital adjunct to overtaxed medical, nursing and hospital facilities, and will be of inestimable value to the nation in the event of epidemics or national defense emergencies. . . .

For adults the course takes six weeks, covering 24 hours of class instruction, of which 70 per cent consists of practice work making use only of such equipment which the average family would be expected to own. Positive health measures are stressed, as well as subjects such as care of babies, children and the aged. Under no circumstances does the certificate presented for completion of the course entitle the receiver to serve outside her home for remuneration. Nor is the instruction intended to eliminate the need of professional medical or nursing assistance.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

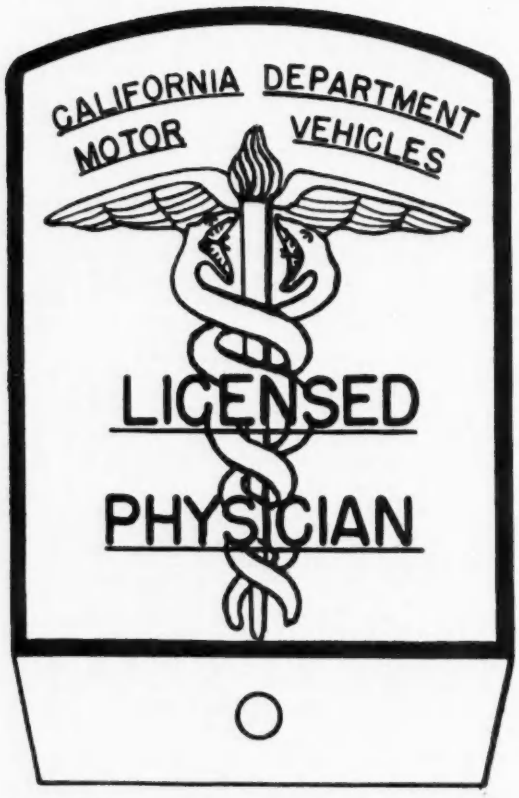
Approved Insignia for Licensed Physicians

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
CALIFORNIA HIGHWAY PATROL

September 13, 1941.

Pursuant to Section 454.2 of the Vehicle Code, effective September 13, 1941, the insignia indicated below has been approved and may be displayed by licensed physicians. Said



insignia shall exempt licensed physicians from Section 511, Prima Facie Speed Limits, when traveling in response to emergency calls.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

The insignia must be displayed upon the rear of the vehicle and must conform to that shown below, which has been approved by the Department.

Approximate Size—Three inches wide by 3¼ inches high.

Color—Border, letters, outlines, wings: tan. Snakes: light green. Staff: chromium plate. Torch: flame red. Background: cream.

(Signed) JAMES M. CARTER,
Director, Department of Motor Vehicles.
(Signed) E. RAYMOND CATO,
Chief, California Highway Patrol.

* * *

For the convenience of members who did not read the editorial comment in the September issue of CALIFORNIA AND WESTERN MEDICINE, concerning the new traffic law relating to physicians, the following comments may be of interest:

At the Coronado meeting, Doctor Bullock of Los Angeles introduced Resolution No. 24 for proposed legislation granting traffic law exemptions to physicians when responding to emergency calls, the same being adopted (CALIFORNIA AND WESTERN MEDICINE, June, 1940, pages 271 and 294). An act drafted and introduced as Assembly Bill 690 went on to enactment, now being recorded as Chapter 573, Section 454.2 of the Vehicle Code of California. Reference to this measure is made under Item 20 of the minutes of the California Medical Association Council, appearing in this issue on page 144.

The text of the new law which, with other statutes, will become operative ninety days after the June 14 adjournment, namely, on September 3, reads as follows:

"The people of the State of California do enact as follows:

"Section 1. Section 454.2 is hereby added to the Vehicle Code, to read as follows:

"454.2. Vehicles Owned by Physicians. A physician traveling in response to an emergency call shall be exempt from the provisions of Section 511 of this code; provided, the vehicle so used by him displays an insignia approved by the Department of Motor Vehicles, indicating that such vehicle is owned by a licensed physician. The provisions of this section shall not relieve the driver of any such vehicle from the duty to drive with due regard for the safety of all persons using the highway, nor shall the provisions of this section protect any such driver from the consequences of an arbitrary exercise of the privileges declared in this section."

It is to be regretted that the statute did not provide that the special insignia, to be placed on automobiles, should be secured from the California Department of Motor Vehicles, through applications previously approved by the state examining boards of physicians. However, the beginning has been made.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

San Diego Postgraduate Conference

Under the auspices of the San Diego County Medical Society, a postgraduate conference, conducted on three successive evenings, was carried through on Tuesday, Wednesday, and Thursday, October 28, 29, and 30.

The first session was a dinner meeting at the University Club, on Seventh Avenue, held on Tuesday evening at 6:30 o'clock.

The second meeting took place in the auditorium of the Mercy Hospital, on Hillcrest Drive, on Wednesday at 7:30 p. m.

The last of the three meetings was also held in the auditorium, Mercy Hospital, on Thursday at 7:30 p. m.

The members of the following county medical societies were invited: San Diego, Imperial, Orange, Riverside, and San Bernardino.

Program follows:

Tuesday, 6:30 p. m., October 28

Guest Speaker: John C. Ruddock, M. D., Los Angeles.
On: Ascitis; Palpable Liver; Alcoholism; Ascitis in Women; Vague Upper Abdominal Pains; Latent Jaundice.

Wednesday, 7:30 p. m., October 29

Guest Speaker: Eric Larson, M. D., Los Angeles.
On: Duodenal Ulcer; X-Ray Diagnosis of Cancer of Stomach; Exploratory or Abdominal Adhesions with Vomiting and Distress; Esophageal Hernia.

Thursday, 7:30 p. m., October 30

Guest Speaker: William C. Boeck, M. D., Los Angeles.
On: Acute Gastritis, Such as Is Seen from Alcoholism; Hemorrhagic Gastritis; Massive Hemorrhage of the Stomach and Its Treatment; The Diagnosis and Treatment of Penetrating Gastric Ulcers.

* * *

Eighth Councilor District Postgraduate Conference

In Chico, at Hotel Oaks, on Saturday afternoon and evening, and Sunday morning and afternoon, November 1 and 2, the members of the Eighth Councilor District held a two-day Postgraduate Conference—their second—the first having been held last year at Lake Tahoe. The counties of the Eighth Councilor District include: Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo, and Yuba.

The Conference was held under the auspices of the Butte-Glenn County Medical Society. Councilor Frank A. MacDonald of Sacramento and a local committee supervised the arrangements. The dinner and luncheon reservations were in charge of Dr. J. O. Chiapella of Chico.

Program follows:

FIRST DAY: SATURDAY, NOVEMBER 1

2:00 p. m.—*Registration.*
3:00 p.m.—*Postgraduate Conference.*
Chairman, Charles Benninger, Oroville, President, Butte-Glenn County Medical Society

The Clinical Use of Sulphonamide Compounds—Maurice Tainter, Professor of Pharmacology, Stanford University School of Medicine.

Diagnosis and Treatment of Anemia—Stacy R. Mettier, Associate Professor of Medicine, University of California Medical School.

The Treatment of Compound Fractures — Carleton Mathewson, Jr., Associate Professor of Surgery, Stanford University School of Medicine.

7:00 p. m.—*Banquet.*
Toastmaster, Dan Moulton, Chico, Past President, Butte-Glenn County Medical Society.
Speaker: Honorable Charles H. Deuel, Chico, Senator, Sixth California District.
Subject: Medical Legislative Problems.

9:00 p. m.—*Entertainment:* Music, cards, refreshments, etc.

SECOND DAY: SUNDAY, NOVEMBER 2

8:00 a. m.—*Breakfast.*
9:00 a. m.—*Postgraduate Conference.*
Chairman, Joseph O. Chiapella, Chico, Secretary Butte-Glenn County Medical Society

The Treatment of Hemorrhagic Diseases—Stacy R. Mettier, Associate Professor of Medicine, University of California Medical School.

The Recognition and Treatment of Acute Bowel Obstruction—Carleton Mathewson, Jr., Associate Professor of Surgery, Stanford University School of Medicine.

The Medicinal Treatment of Gastro-Intestinal Conditions—Maurice Tainter, Professor of Pharmacology, Stanford University School of Medicine.

1:00 p. m.—*Luncheon—Organization Meeting.*
Chairman, Frank A. MacDonald, Sacramento, Councilor, Eighth District

Remarks—Henry S. Rogers, President, California Medical Association.

Medical Practice Act—William R. Molony, President-Elect, California Medical Association.

Organization Activities—George H. Kress, Secretary-Editor, California Medical Association.

Basic Science Initiative—John Hunton, Executive Secretary, California Medical Association.

Medical Legislation—Ben H. Read, Executive Secretary, Public Health League of California.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Southern California Chapter: American College of Surgeons

Three hundred members of the Southern California Chapter of the American College of Surgeons continued their clinical observations in Los Angeles hospitals recently.

From ward to ward went the visiting scalpelmen, eyeing condition charts, hearing surgeons explain cases, offering their talent freely in many an impromptu bedside consultation.

At California Hospital they discussed deadly carcinoma, that strange malignant proliferation of wild cells that chokes the channels of life.

At Cedars of Lebanon they heard much of patching the body's inner tubes, as prominent local surgeons explained their technique of dealing with ailments of the colon.

At Hollywood Hospital obstetrical pathology was programmed, and at Orthopedic Hospital a lot was said about the diseases of children.

Afflictions of the eye, ear, nose, and throat were investigated at the Los Angeles County Hospital, and at Good Samaritan Hospital various difficult surgeries were studied.

At the Los Angeles County Medical Association building the surgeons listened to lectures on medication—what to do if surgery fails, or how to aid repair jobs with healing drugs.

These include vitamins, hormones and various minerals, including iodin, which are coming to be used as adjuncts to surgery.

Uses of the newer sulfonamide drugs in their relation to the control of surgical conditions is being clarified, states a note on the program of the convention.

* * *

Dr. Donald G. Tollefson of Los Angeles was elected president of the Southern California Chapter of the American College of Surgeons at an annual banquet and election, which climaxed a two-day session of the organization in the Los Angeles County Medical Association building.

Dr. Charles M. Fox of San Diego was elected vice-president of the group, and Dr. Harold Lincoln Thompson of Los Angeles was installed as secretary-treasurer.

Executive committeemen elected were: Doctors Henry V. Findlay of Santa Barbara, Thomas Card of Riverside, Jacob H. McCracken of San Pedro, and Carl Rusche and Ray Irvine of Los Angeles.

* * *

Doctor Winslow Teaching at California

Dr. C. E. A. Winslow, Professor of Public Health at Yale University, has been appointed Rosenberg Lecturer in Public Social Services at the University of California for the fall semester of 1941.

* * *

Inactive Duty Training: Medical Reserve Officers' Conferences

The attention of Medical Reserve Officers is called to a communication in the Letters department of this issue regarding monthly conferences to be held at the Presidio of San Francisco (see page 276).

* * *

Salmon Memorial Lectures: In San Francisco

Final dates for the Salmon Memorial Lectures which Dr. Robert D. Gillespie, psychiatric specialist of the British Royal Air Force, will deliver in key cities of this country and Canada, have been announced by Dr. C. Charles Burlingame, chairman of the Salmon Committee on Psychiatry and Mental Hygiene. The schedule of lecture dates was completed after an exchange of cables between the Salmon Committee and Sir Harold Whittingham, Director General of the Medical Services of the Air Ministry in London.

Doctor Gillespie has received special leave of absence from the RAF from the British Government for the express purpose of delivering the Salmon Lectures in this country and Canada. He will fly here to make a first-hand report to members of the American medical profession and officers of the United States Army and Navy Morale Division on the psychological effects of "blitz" warfare on civilian and armed forces.

The tentative date for Doctor Gillespie's appearance in San Francisco is Thursday, November 27, under the sponsorship of Leland Stanford University, University of California, and the San Francisco Psychiatric Society.

Doctor Gillespie's observations, made under actual war conditions, are expected to be of inestimable value to American psychiatrists in formulating plans for maintaining civilian morale in wartime.

A general invitation to members of the medical profession and their friends to attend the lecture has been issued by the Salmon Committee. Doctor Gillespie will be the ninth lecturer who has been selected from top-ranking psychiatrists and neurologists throughout the world for making the greatest contribution to their field during the preceding year. Selection for the Salmon Lectures has been likened to selection in the Pulitzer prize in letters.

* * *

California Mental Hygiene Society

Personality Problems to Be Discussed

Personality problems and their treatment is the subject of five case presentations to be given by the Northern California Mental Hygiene Society on successive Wednesday evenings during November and December, beginning on November 12.

The *chronic alcoholic* will be considered at the November 12 session. Dr. Percy Poliak, Director of the Clinic for Alcoholics at the San Francisco Hospital, will present the case study. A member of the San Francisco Police Department and of the Department of Social Welfare will discuss the problem from their point of view. The psychological mechanisms involved in the behavior of the alcoholic and methods of treatment, including those of the alcoholics anonymous, will be discussed.

The *adult psychiatric problem* will be presented on November 19 by Dr. Sophie Merviss, psychiatrist, from the Mount Zion Psychiatric Clinic. A social worker and psychiatric social worker will demonstrate how they coöperate with the psychiatrist in working out the problem.

Psychiatric therapy in family relations will be discussed on November 26. Irma Blethen of the Family Service Agency will present a case. Dr. George Johnson and Pearl Axelrod will show how the psychiatrist and psychiatric social worker work out a program of therapy with a community agency.

The problem child and what can be done for him in a child-guidance clinic will be the basis for discussion on December 3. A social worker, psychologist, and pediatrician will demonstrate what each specialist contributes in solving this problem. Dr. Hale Shirley, Director of the Child-Guidance Clinic at Stanford University Hospital, will give the case presentation. Dr. Mary Layman, professor of pediatrics, and Dr. Joseph Solomon, psychiatrist, will also appear on this program.

The relationship of *vocational adjustment* to the solution of other personality problems is the subject of the conference on December 10. Methods of diagnosis and job placement will be discussed by Barbara Mayer, Supervisor of the Counseling Service of the State Department of Employment. Mary Rapp, psychologist, will assist with the case presentation. Dr. Edwin Ghiselli of the University of California and Max Levin, psychologist from Homewood Terrace, will discuss the work of this clinic in the community.

The case discussions will be held at 8 p. m. at the Sorosis Club auditorium, 536 Sutter Street. For further information, address Northern California Mental Hygiene Society, 45 Second Street, Room 409, San Francisco.

* * *

Southern California Medical Association—105th Semi-Annual Session

The Southern California Medical Association will hold its 105th semi-annual meeting on Friday and Saturday, November 14 and 15, 1941, at the Huntington Hotel, Pasadena. A program has been arranged which includes subjects of sufficient general interest to be of value to the specialist and general practitioner alike.

The Association is fortunate in having secured two outstanding guest speakers.

Dr. Karl Meyer, Director of the Hooper Foundation for Medical Research at the University of California, will address the Association and will act as moderator for a symposium on "Chronic Fevers."

Dr. Charles E. Smith, Professor of Public Health at Stanford University School of Medicine, will also address the Association. Doctor Smith is a noted authority on coccidioidomycosis and on many problems relating to public health.

It is sincerely hoped that whether or not you are a member of the Association, you will avail yourself of the advantages of the forthcoming meeting.

For further information, address Edward W. Boland, M. D., 2202 West Third Street, Los Angeles.

COMMITTEE ON INDUSTRIAL PRACTICE

Rule 19 of the Industrial Accident Commission—the rule requiring the furnishing of all medical reports in litigated compensation cases—was hardly dry on the books before one large insurance company sent form letters to all physicians handling its medical work, asking that in all industrial accident cases the physician furnish the insurance company with five copies of all medical reports.

While the adoption of the Commission's new rule caused no sensation among the doctors, the insurance company's form letter drew an immediate response. Discussion brought out the fact that most doctors' offices are not mechanically equipped to handle multiple copy typing, that there is a large expense involved in extra time, stationery, supplies and care, and that there is nothing in Rule 19 to require that copies of medical reports be carbons of the doctor's original report. There was considerable grumbling about the insurance company's trying to push off on the doctors the extra clerical work involved in Rule 19.

At the request of several members, the California Medical Association central office talked this matter over informally with the insurance company which had asked for the extra copies of reports. It was pointed out that more than 80 per cent of all industrial accident cases require only treatment and never get to the stage of litigation. Of the 20 per cent on which compensation is allowed after the legal waiting period, not more than half (or about 10 per cent of all industrial accident cases) go into litigation, which would require the filing of additional copies of medical reports.

On the strength of these representations, the insurance company has agreed to make its own copies of medical reports where they are needed. Any doctor who feels he should not carry the burden of extra clerical work demanded by the insurance company's original request is at liberty to ignore the request.

In case the Industrial Accident Commission should rule at a later date that all copies of medical reports must bear the doctor's own signature, the California Medical Association can take appropriate action. With all industrial compensation work being done at fees that are admittedly low, there appears no adequate reason for additional office burdens to be placed on the doctors.

* * *

Council on Industrial Health, American Medical Association

State Committee Activity

Recent meetings which have been held in Michigan, Indiana, and Kentucky, suggest that a restatement of the original program of activities designed for committees on industrial health in state and county medical societies would be helpful. The following is a brief summary of the plan presented in Bulletin No. 3, which recommended three main types of activity:

1. *Investigation.*

(*a*) The medical needs of industry can only be determined through familiarity with the character of industrial processes, hazards and health programs existing in the community.

(*b*) A census of the physicians specializing in, or giving attention to, industrial practice with their industrial connections and the scope of the service they provide should be compiled.

(*c*) The type of service that the private practitioner can render to the small plant through a health maintenance program needs investigation.

(*d*) Physical examination is the most likely basis for early common interest to industry and the physician alike and needs careful study and control.

2. *Correlation.*

(*a*) The activities of local organizations which are or should be interested in industrial health problems needs coördination to avoid duplication of effort. The list should include: Health departments, industrial hygienists, industrial nurses, safety councils, manufacturers' associations, labor organizations, casualty insurance adjusters, and bar associations.

3. *Education.*

(*a*) Education of the medical profession by all available means for instruction about the services that can be rendered to industry is a direct responsibility of the state and county committees.

(*b*) The educational program should also include proper instruction of industrial nurses, plant management, employees, and the general public about the benefits of industrial health services.

(*c*) The responsibility for developing a program of industrial health to meet present-day needs must lie primarily with the committees organized for that purpose in the state medical societies. The extension of a policy of guidance and inspiration to county society committees should yield much wider and more intensive activity. It is in the county society where the acute problems of an industrial-medical nature are encountered and where they can be most directly dealt with. More intimate contacts made by a larger number of the medical profession, will mean far greater influence upon standards in industrial practice.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (25)

Imperial County (1)

S. R. Edwards, *El Centro*

Monterey County (1)

Sebastian A. Carnazzo, *Monterey*

Riverside County (2)

Richard N. Boylan, *Riverside*
Charles J. Miller, *Riverside*

San Diego County (1)

J. B. McConnell, *San Diego*

San Francisco County (12)

Jack Kenneth Afflerbaugh, *San Francisco*
August A. Antipa, *San Francisco*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Isaac Arnowitz, *San Francisco*
Charles H. Cutler, *San Francisco*
Edward E. Fong, *San Francisco*
Maurice L. Kamins, *San Francisco*
Frances M. Keddie, *San Francisco*
Elise M. Rose, *San Francisco*
Elliot G. Schneider, *San Francisco*
Thomas L. Schulte, *San Francisco*
Richard Clifford Smith, *San Francisco*
Forrest M. Willett, *San Francisco*

Santa Cruz County (2)

A. David Garibotti, *Santa Cruz*
Frances M. McKay, *Santa Cruz*

Tulare County (5)

George B. Armanini, *Sunnyvale*
E. K. Blasdel, *Tulare*
W. D. Clinite, *Tulare*
A. W. Dagoberg, *Porterville*
Cyril H. Johnson, *Tulare*

Ventura County (1)

John N. Stewart, *Santa Maria*

Resigned (1)

John Aloysius Fershtand, from San Francisco County.

In Memoriam

Baron, Peter Paul. Died at Alameda, September 17, 1941, age 49. Graduate of College of Physicians and Surgeons, Los Angeles, 1918. Licensed in California in 1921. Doctor Baron was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Bogle, Samuel Saffell. Died at San Francisco, September 27, 1941, age 74. Graduate of University of Tennessee College of Medicine, Memphis, 1891. Licensed in California in 1893. Doctor Bogle was a member of the Sonoma County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Kell, Fred B. Died at San Bernardino, April 22, 1941, age 53. Graduate of St. Louis University School of Medicine, Missouri, 1913. Licensed in California in 1914. Doctor Kell was a member of the San Bernardino County Medical Society, the California Medical Association, and the American Medical Association.

✝

Martin, Albert Thomas. Died at Los Angeles, September 16, 1941, age 43. Graduate of Johann Wolfgang Goethe Universität, Medizinische Fakultät, Frankfurt-am-Main, Prussia, 1922. Licensed in California in 1924. Doctor Martin was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Morrow, Howard. Died at San Francisco, October 22, 1941, age 66. Graduate of University of California Medical School, San Francisco, 1896. Licensed in California in 1896. Doctor Morrow was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Reynolds, Frank Chester. Died at Chico, September 20, 1941, age 32. Graduate of University of Southern California School of Medicine, Los Angeles, 1935. Licensed in California in 1935. Doctor Reynolds was a member of the Butte-Glenn County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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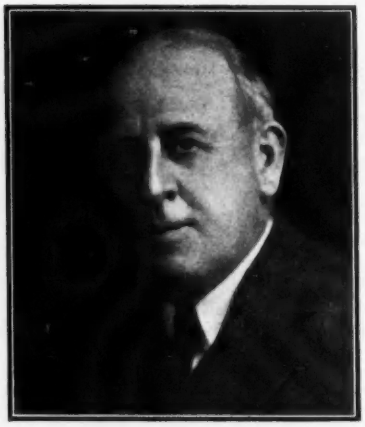
OBITUARY



Howard Morrow
1874–1941

Howard Morrow, nationally noted physician and a former vice-president of the American Medical Association, died at his home in San Francisco on Wednesday afternoon, October 22, 1941.

His death from a heart attack came as a shock to the medical profession and to thousands who had known him during his nearly half a century of practice.

A native San Franciscan, born November 12, 1874, Doctor Morrow was graduated from the University of California Medical School in 1896, and later became clinical professor of dermatology in his alma mater, and remained as head of the dermatology department up to the time of his death. He was president of the American Dermatological Association in 1918, and was a member of the Dermatological Associations of Great Britain and of Vienna.

He was elected vice-president of the American Medical Association in 1938 during its national convention in San Francisco.

In the past decade, he had been president of the California Medical Association (1937), and president of the State Board of Public Health (1933-1940).

For many years, Doctor Morrow was a consulting physician for the U. S. Marine Hospital and the United States Public Health Service.

As head of the California State Board of Public Health, he was instrumental in launching many important investigations concerning the causes and prevention of communicable diseases.

Doctor Morrow was a member of Alpha Kappa Kappa, Alpha Omega Alpha, the Family Club, the Olympic Club, and the Menlo Country Club.

He leaves a widow, Mrs. Mary Weldon Morrow, a daughter, Mrs. Maryle Doerflinger; three sons, Weldon, Robert and Dr. Grant Morrow, and a brother, William G. Morrow of San Francisco.

In the medical profession and among his friends and fellow citizens he was much beloved, and his passing leaves a distinct void. His will be a difficult place to fill.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

Meeting of Board of Directors

On Friday, September 19, Mrs. Harry O. Hund, State President, met with her Board of Directors in an all-day session at the Women's City Club in San Francisco. The following officers and directors were present:

Officers: Mrs. Harry O. Hund of San Rafael, president; Mrs. F. G. Lindemulder of San Diego, president-elect and chairman of finance; Mrs. R. Stanley Kneeshaw of San Jose, first vice-president and chairman of membership and organization; Mrs. Ralph B. Eusden of Long Beach, second vice-president and chairman of program and health education; Mrs. R. K. Cutter of Berkeley, recording secretary; and Mrs. Frank A. Lowe of San Francisco, corresponding secretary.

Councilors-at-Large: Mrs. Rene Van de Carr of Piedmont, chairman of publicity.

District Councilors: Mrs. G. W. Coon of Riverside, Mrs. Franklin Farman of Los Angeles, Mrs. Allan J. Pederson of Santa Cruz, Mrs. M. R. Gordon of San Francisco, Mrs. Kaho Daily of Richmond, Mrs. Charles C. Landis of Chico, and Mrs. H. R. Madeley of Vallejo.

Chairman of Committees: Mrs. Hobart Rogers of Oakland, parliamentarian; Mrs. Lincoln Brown of San Francisco.

Mrs. Edmund J. Morrissey of San Francisco, treasurer; Mrs. Eric Colby of Bakersfield, chairman of public relations; Mrs. R. Emerson Bond of San Diego, chairman of public health activities; Mrs. Franklyn D. Hankins of Riverside, chairman of *Hygeia*; Mrs. J. C. Sharp of Salinas, convention chairman; Mrs. Arthur T. Newcomb of Pasadena, historian. Mrs. Louis A. Packard and Mrs. J. C. McClure, district councilors, were absent.

The following county presidents attended: Mrs. C. C. Landis, Butte; Mrs. J. R. Walker, Fresno; Mrs. H. N. Hensler, Marin; Mrs. Martin McAulay, Monterey; Mrs. Gustave Wilson, Sacramento; Mrs. E. R. Christopherson, San Diego; Mrs. Norman Sullivan, Santa Cruz; Mrs. Eugene Kilgore, San Francisco; Mrs. O. A. Sharpe, San Mateo; and Mrs. F. B. Jones, Solano.

Mrs. Hund graciously welcomed members of the Board and the County presidents, and then presented her splendid program for the year 1941-1942. Reports of the committee chairmen showed their work to be well planned for the coming year. All old business was finished promptly, and much new business was discussed.

Mrs. Hund introduced Mr. Ben Read, Executive Secretary to the California Public Health League, who explained the Basic Science Law, which is now in effect in fifteen states and the District of Columbia; California being the only Pacific Coast State which does not have such a law requiring training in the basic sciences for all who practice the art of healing (Christian Science exempted). Mr. Read said that the Auxiliary can help in securing the 30,000 signatures for the petitions being circulated, the number of signatures required to put this initiative on the ballot.

At 12:30 the San Francisco Auxiliary honored Mrs. Hund and her Board at a delightful luncheon in the City Club. Mrs. Eugene Kilgore, president of the San Francisco group, presided. Entertainment included a visit to the National Defenders' Club, and an automobile tour to places of interest in the city.

* * *

News Items

The Alameda County Auxiliary has planned its annual benefit party. It will be a bridge luncheon and Fashion Show, to be held at the Athens Athletic Club in Oakland on the regular meeting day. Mrs. George E. Kleeman is general chairman, and the models have been chosen from the membership.

The Fashion Show has been patterned on a musical theme, "A Pretty Girl Is Like a Melody," played and arranged by the Mesdames Chelsea Eaton, Milton H. Shutes, and G. Kenneth Hargrove. Proceeds from this event are to go to the Medical Benevolent Fund.

* * *

The Contra Costa Auxiliary is having a luncheon for its members in October, and has also sent invitations to Auxiliary members in neighboring counties.

The luncheon will be given at Tisbury Farm, on Walnut Creek, and will be followed by a talk on *The Third Component* by Dr. Frederic M. Loomis of Alameda County.

* * *

Humboldt County Auxiliary opened its first meeting of the year with a seven o'clock dinner at the Humboldt Golf and Country Club.

Mrs. Harry O. Hund of San Rafael, President of the State Auxiliary, was the guest speaker of the evening. A woman of unusual and charming personality, Mrs. Hund gave an interesting and instructive talk on national defense, and the duties of a doctor's wife and family toward his profession. She also gave a brief summary on the new Auxiliaries that are being organized throughout the state. Her unique suggestions as to how funds for the various projects could be raised were received with enthusiasm by the members.

* * *

Kern County Auxiliary started its fall activities with an evening meeting held at the home of Dr. and Mrs. Seymour Strongin. After disposition of the regular business, a reading of *White Cliffs of Dover* was enjoyed by the members.

* * *

The Los Angeles County Auxiliary entertained with a membership tea for new members, and all eligible members, in the beautiful home and gardens of its president, Mrs. William C. Boeck, in Beverly Hills, on September 28.

* * *

Members of the Marin County Auxiliary had their first fall meeting at Deer Park Villa in Fairfax. The most important business transacted was the decision to give $15 immediately to the State Benevolent Fund.

The members adjourned to a later date, to join their husbands at a dinner and hear talks by Mr. Ben Read and Mr. John Hunton on legislative matters and the Basic Science Law.

* * *

Members of the Merced County Auxiliary also had a meeting to honor the State president, Mrs. Harry O. Hund, at the Tioga Hotel. Mrs. Hund stressed social betterment and various ways the local group might extend its activities with the advice of the State Medical Association.

* * *

San Diego County Auxiliary held its first meeting in the Don Room of the El Cortez Hotel with a business session and luncheon. Many new and prospective members were present, and, as special guests, the wives of Army and Navy doctors were included.

Bridge and bingo were enjoyed following the luncheon, and a teller told fortunes throughout the afternoon.

* * *

The San Francisco Auxiliary held its first meeting with business and entertainment programs. Dr. Harold Fletcher, President of the San Francisco County Medical Association, addressed the members and asked all to

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front of advertising section.

participate actively in all civic affairs that touch upon medicine.

Judge Theresa Meikle of the Municipal Court, as guest speaker, discussed the newly organized "Big Sister Plan," a help for girls needing advice and guidance.

The foremost activity of the autumn will be the sponsoring of a day at the San Francisco House of Hospitality in the Civic Center from 10 a. m. until 11 p. m. on Wednesday, November 5. (This is the contribution of San Francisco to men in the Government service.) Sandwiches, cakes and coffee are to be served during the day and evening, and girls, chaperoned by doctors' wives, have been invited for dancing.

Proceeds from a spring bridge party were sent to the California and Stanford Universities as a loan fund for senior medical students.

* * *

What promises to be a busy season has been inaugurated by the Santa Barbara Auxiliary. At the business meeting there was discussion of organizing a defense group within the Auxiliary to work under the Red Cross, probably to roll bandages.

Members also discussed the needs of the Girl Scout Troop which was sponsored by the Auxiliary, and plans were made to help them with a benefit tea later in the fall.

Each year the Auxiliary awards a prize of $10 to a nurse graduating from Knapp College at Cottage Hospital, who, in the opinion of the Staff, has the best bedside manner.

The meeting was followed by a tea, honoring the Army wives from Hoff General Hospital.

* * *

Santa Clara Auxiliary members as a whole are enthusiastically centered in their Community Chest Drive, and members have also volunteered to carry out the sewing and knitting program set out by the Red Cross and the British War Relief program. The first fall meeting was held in the home of the president, Mrs. George Gray, and was followed by a reading of a play by Mr. Lawrence Mendenhall of the State Teachers' College.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
September 30, 1941	30,215

Report to Professional Members: Announcement of Changes in Plan

Your Board of Trustees submits herewith a report of developments to professional members of California Physicians' Service.

California Physicians' Service has just completed its second year of operation. During the last year we have had an average membership of over 20,000 and have now reached 30,000. Our experience during the first year could not be considered as a valid basis for conclusions that the Service was either good or bad. In the second year of operation, however, our mechanics and techniques have been crystallized into fairly uniform procedures and methods and we may accept the findings of this second year with considerable confidence.

PIONEERING WITHOUT PRECEDENT

One of our most serious handicaps has been the lack of a similar operation that we might adopt as a pattern. No other organization has attempted this job on as broad a basis as California Physicians' Service. We could not pattern ourselves after existing private plans because it was not our intent to run a commercial enterprise but rather to develop a health service plan to meet the needs of the public and of the profession. We have been compelled to do a great deal of pioneering work in the past two years, but we have now reached a point where we feel quite confident of our course in the future.

OUR OBJECTIVES

During these past two years we have been trying to do two things: First, to determine the possibility, the cost and the mechanics of administration of an unlimited free choice medical service plan, and, second, to run a business-like operation which would pay the doctor a reasonable fee for his service. We have accomplished the first objective, but only at some sacrifice of the second. We must now mould our service and procedures so as to secure and maintain both of the original objectives.

FULL COVERAGE CONTRACTS

Almost all of the members comprising our present 30,000 have their membership under the full coverage contract which provides them free access to the doctor of their choice for any illness or injury, large or small. Under this contract California Physicians' Service sets no maximum limit on the quantity or quality of care that the doctor may wish to extend, except the limit of one year's treatment in any single illness or injury. This contract was offered to the public as an example of what the medical profession felt that a health service plan should be. It was necessary to determine the change in the habits of people and in their attitudes toward the use of medical service when they had unlimited access thereto. It must be obvious that we could not set up any arbitrary controls against the natural expression of these attitudes and habits if we expected to find the truth. We have found that the change has been radical and that the incidence of use of service has reached a height beyond our wildest predictions.

Nevertheless, it is well that we know these things. In fact, it is necessary. *If we are to arm the medical profession with "expert testimony" to prove the fallacy of government proposals for unlimited health insurance, we must secure this information from a plan equally as broad and as unlimited as those which are being proposed by government. Furthermore, this information must be current and secured from a live and going organization of considerable size if it is to be given any weight.*

Our membership of 30,000 is scattered throughout the state, with representation in every county. This is sufficient to give us an honest sample of experience with California medicine on a free and open access basis. It should be reëmphasized that any conclusions drawn from our experience are only valuable if our organization is a going one. Great capital would be made out of any attempt on our part to eliminate this program.

NECESSITY OF PROVIDING MORE EQUITABLE PROFESSIONAL FEE

Practical thinking suggests that if we are to continue the full coverage plan we must also devise new plans which will produce a more equitable fee for the professional services performed and which, combined with the full coverage plan, will not require a heavy contribution from the profession. This contribution will be relatively small in 1940 and 1941. Our present information permits us to modify our full coverage contract to secure a more equitable balance in the unit value without destroying our original concept of what this service should be.

We believe that the administrative phase of the plan is now well in hand. Our actual administrative expenses are well below the original maximum set for this purpose, and with increasing volume we can expect still further better-

†Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook, 3211. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

ment. Even though we have pioneered in a business which had no precedent, we have been able to reduce our requirements of paper work and reports from doctors to a bare minimum. We must continue to study closely our experience with our present groups not only actuarially, but with respect to its effect upon the medical profession throughout the state. We have already recognized the wide differences in the practice of medicine in rural, urban, and metropolitan districts. The ultimate plan must give serious consideration to these factors as well as to actuarial results.

GROWTH OF CLOSED PANEL SYSTEMS

We must also study the activities of the "closed panel systems" in order that we may have an answer to the intrusions of these methods into the field of private practice. These "closed panel systems" *employ physicians on salary* to render medical care which has been *sold to the public* on a prepaid *contract* basis. These activities are gaining footholds in California at a far greater speed than is generally realized. Many thousands of *potential patients* have already been *taken away from private practice* by these "closed panel systems" which do not recognize any income limits. Their presence is very definitely felt in all parts of the state where California Physicians' Service representatives discuss health services with groups.

FACTS ESTABLISHED

In our study of the full coverage contract and our experience thereunder, we find certain facts:

1. Our incidence of illness averages better than 17 per cent, that is, almost one-fifth of our total membership is under treatment each month. This is much higher than the predictions based upon any surveys or other static forms of measurement.

2. The extent of service rendered to these patients is such that, on the average, medical service costs are equal to one unit of service per dues-paying member per month. An extremely large part of the services required by beneficiary members is for minor ambulatory illnesses and for chronic conditions.

3. Of the cases under treatment in a single month, nearly 40 per cent are continued from the previous month.

It is a very reasonable assumption that the high frequency of the use of the service, the high proportion of minor illnesses, and the dragging on of these cases is the result largely of a complete lack of responsibility on the part of the beneficiary. He need not count cost in any fashion, but merely has to present himself to the doctor and ask for whatever may be available.

4. Fifty-six per cent of our membership is composed of women who require almost 75 per cent of the care extended.

5. Too high a percentage of all membership has been secured in the white collar classes and we have not been able to secure a sufficient percentage in the industrial groups.

These last two items confirm the necessity for our expansion into new fields in order to secure a proper balance of low-income members in our Service.

6. There does not seem to be any evidence of "chiseling" on the part of professional members to any significant degree. There is no excess of services in any particular district in terms of number of patients treated nor in terms of quality of service rendered per patient.

POSSIBLE SOLUTIONS

With these facts in our possession we can plan for betterment. We have three possible solutions: First, raising dues; second, inserting some elements of cost sharing; third, a low-cost limited plan.

Item one does not propose a very practical solution by itself. Raising dues would no doubt eliminate a considerable number of our present members, and such elimination would be largely among the low income members and not among the higher income members, who have less need for the protection of the Service. However, we may do something to raise the unit value without unfairly affecting the membership as a whole. As noted above, women require 20 per cent more medical care, in proportion to their number, than the men. It seems reasonable, then, there should be an adjustment of rates for women to correct this situation.

Item two may be the source of considerable betterment. We propose that some responsibility shall be put upon the member so that he may feel a share of the burden in direct proportion to his use of the Service.

Item three is the most important with respect to policy and with respect to actuarial results. The high rate of dues necessary for the full coverage resulted in automatic selection of the "white collar" groups, who were the first to recognize the benefits to be secured through this service. Therefore, in order to correct this, we must now offer a low price plan that will attract the low income and industrial worker.

One of the most important factors we need to balance out the whole is volume, and volume can be secured with safety under limited plans which include only predictable and insurable factors. In this expansion we shall have the benefit of the experience of Eastern and Middle Western medical service associations. These organizations have found their experience entirely satisfactory with this type of contract. They have been able to secure very ready acceptance from the low income industrial groups of these limited service plans. If we can acquire volume under these contracts, it will put us definitely and safely into the low-income field. These industrial groups have not been educated to pay for a complete medical service, but in the experience of other medical service associations, once they have had the limited plan for a reasonable period of time, they manifest interest in the broader plans.

Therefore, we intend to put forth all of our effort on the acquiring of groups in the industrial field under this type of contract, limiting our acquisition activities in the full coverage plan to the two-visit deductible contract only.

CHANGES MADE BY TRUSTEES

The following changes in policy were made at the meeting of the Board of Trustees on September 20, 1941:

1. A raise in the dues for women in all new groups effective October 1, 1941, and raises in dues for women in existing groups according to our experience and as the contracts expire.

2. A moratorium upon the sale of full-coverage contracts, limiting the sale of this service to the two-visit deductible contracts only (wherein the member pays the cost of the first two visits).

3. Authorization to the secretary to cancel or modify contracts with existing groups where experience indicates abuse of the service.

4. Authorization to the Executive Committee to develop means for the inclusion of dependents of the wage-earner under the limited surgical plan.

5. Direction to the Acquisition Committee to place all of its emphasis upon the limited surgical contract in future acquisition.

The question, naturally, arises as to the over-all effect of these changes. Your Board of Trustees feels that the modification of our full-coverage contract and this expansion into new fields will result in the following:

1. We will modify our full-coverage plan and we will eliminate unsatisfactory groups.

2. We will reach a new section of the population in the low-income industrial groups.

3. We will balance the ideal full coverage with the businesslike limited coverage.

4. We will extend our service to the industrial worker and his family, whose need for protection is much greater. We assure you that your Board of Trustees is diligent and active in attempting to secure for the doctor a more reasonable return for his services, and to find for the medical profession at large the truth about medical service plans, whether they be voluntary or compulsory.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4–7, 1942.

American Medical Association, Atlantic City, June 8–12, 1942.

American Medical Association Meeting of State Medical Association Secretaries and Editors, 535 North Dearborn Street, Chicago, Friday and Saturday, November 21 and 22, 1941.

Forum on Allergy: Fourth Annual Conference, Detroit, Michigan, January 10 and 11, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts.*

Los Angeles County Medical Association.

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of November, 1941:

Saturday, November 1—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 1—KFI, 10 a. m., The Road of Health.
Saturday, November 8—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 8—KFI, 10 a. m., The Road of Health.
Saturday, November 15—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 15—KFI, 10 a. m., The Road of Health.
Saturday, November 22—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 22—KFI, 10 a. m., The Road of Health.
Saturday, November 29—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 29—KFI, 10 a. m., The Road of Health.

Children's Bureau Needs Maternal and Child Health Specialists.—Employment registers are to be established by the Civil Service Commission to fill maternal and child health specialist positions in the Children's Bureau of the Department of Labor. Vacancies in similar positions in state agencies coöperating with the Children's Bureau may also be filled from these registers at the request of the states concerned. The examination announcement just issued by the Civil Service Commission to recruit persons for these positions, which pay from $3,200 a year to $5,600 a year, allows the filing of applications until November 15, 1941.

There are three options in which persons may qualify—pediatrics, obstetrics, and orthopedics. For each of these options employment lists will be established for administrative, research, and clinical positions. . . .

Persons who wish to apply for this examination are advised that further information and application forms may be obtained from the Commission's representative at any first- or second-class post office or from the central office in Washington, D. C.

Cyclotron Valuable to Medicine.—The cyclotron is a new hope in medicine's search for the causes and treatment of diseases, according to Dr. John H. Lawrence, in charge of medical applications of the University of California atom-smasher.

Doctor Lawrence delivered the Caldwell Lecture at the annual meeting of the American Roentgen Ray Society.

Doctor Lawrence pointed out that valuable contributions to biology have been made, using the artificial radio-active elements produced in the cyclotron, but that "the surface has only been scratched."

Already, he pointed out, one of these elements, phosphorus, has been used to control polycythemia, a rare and fatal disease characterized by an overproduction of the red blood cells.

Radio-active phosphorus has also proved helpful in treating leukemia, a more common fatal disease characterized by overproduction of the white blood cells.

More than a score of the two hundred artificial radio-active elements produced in the cyclotron have proved useful in fundamental biological research, Doctor Lawrence said. Because they decay and emit rays, these elements can be traced in the body and in plants.

He said that the radio-active elements are being built into chemical compounds and dyes commonly found in the body and their distribution traced.

The Caldwell lecturer is chosen for outstanding contributions to roentgenology, the science of the treatment of disease with radiation. Doctor Lawrence is the twenty-second lecturer. Among previous lecturers have been Dr. Robert A. Millikan of the California Institute of Technology and Dr. Walter B. Cannon of Harvard University.

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Erratum.—On page 210 of the October issue, the reference to reprints was in error. These were obtainable from the Los Angeles County Medical Association, although printed by the American Medical Association. The American Medical Association Order Department will send a price list of publications, on application.

Unregistered Births.—A recent birth registration test, conducted by the United States Bureau of the Census, revealed the startling information that there were twenty-eight unregistered births within the jurisdiction of the Los Angeles County Health Department during the four months period under study. Of this number, fifteen were hospital births. Physicians in attendance upon births are urged by the Los Angeles County Health Department Division of Vital Statistics to make certain that birth certificates are properly filed.

Doctor Kellogg Retires.—Dr. Wilfred Harvey Kellogg, the first man to make a bacteriological diagnosis of plague in the United States, retired on September 3.

Born in Kansas, Doctor Kellogg received his medical degree from the University of California in 1896. Shortly thereafter he entered the laboratory of the San Francisco Health Department. It was while there that he made his famous plague diagnosis.

Since that time, with the exception of two years spent with the United States Public Health Service, Doctor Kellogg has been associated in various capacities with the San Francisco Health Department, the California State Board of Health, the Stanford University School of Medicine, and the University of California Medical School.

From 1929 until his retirement he was chief of the Division of Laboratories of the California State Board of Health.

Sulfonamides—Clinical Aids in Recognition of Toxic Effects.—Following item is from the weekly report of the Department of Health of the City of Los Angeles:

In the intensive use of the sulfonamide drugs the resultant publicity following their investigation has sometimes overemphasized their possible toxic manifestation. Though such an attitude is necessary and justified, growing experience with these drugs makes it possible for the average physician to use them freely and without too much worry about their possible toxic effects.

Toxic reactions are frequent, but those which are dangerous are relatively uncommon.

Perrin Long suggests laboratory control whenever possibut, but also notes that practically all the toxic reactions associated with the administration of these drugs can be detected by the physician with *careful clinical control.*

Patients should be seen often and inquiry made for the symptoms of headache, body aching or malaise. In addition, observe the sclerae for jaundice and the conjunctivae for injection or paleness. Jaundiced sclerae, pale conjunctivae may connote impending *hemolytic anemia.* Jaundice without pale conjunctivae probably results from liver damage. Injected conjunctivae and sclerae, together with smarting and burning of the eyes, occurs as a toxic manifestation of sulfathiazole therapy. The oral mucous membrane should be examined and patient questioned for symptoms of sore throat. The latter symptom in patients using sulfonamides for more than one week may indicate the beginning of an agranulocytosis.

The skin should be checked for fine macular rash, which is frequently missed by the patient or his attendant. Patients should avoid direct sunlight and ultra-violet light because of a photosensitization phenomenon.

Temperature should be noted to detect drug fever.

Kidneys: Urine should be watched and measured. Minimum output should not be less than 1,000 cubic centimeters daily. Hematuria is an indication for stopping therapy.

Conclusion: With the possible exception of leukopenia or agranulocytosis, all toxic reactions can be discovered if patient is kept under careful observation. If toxic manifestations appear, these drugs should be discontinued and fluids forced to eliminate them from the system as rapidly as possible.

American College of Surgeons.—In accordance with Article III, Section 5, of the By-Laws, the annual meeting of the Fellows of the American College of Surgeons is called for 1:45 o'clock on the afternoon of Thursday, November 6, 1941, in the ballroom, Copley Plaza Hotel, Boston, Massachusetts. In addition to the routine business, reports of officers and standing committees will be presented. Each Fellow of the College is respectfully urged to be present.

Educational Program of California Tuberculosis Associations.—The annual educational program sponsored by the tuberculosis associations in California is now being planned. It is carried on in April each year, and is known as the "Early Diagnosis Campaign."

The theme for 1942, "Tuberculosis—Find it—Treat it—Conquer it," was selected by the committee of the National Association of Tuberculosis Secretaries; and the material to be used, including pamphlets, leaflets, posters, and charts, was prepared under the supervision of the committee of the American Trudeau Society.

A preview of the material impresses the reader with the modern trends in health education literature. Attractive titles, handsome layouts and printing jobs, and easy-to-read content, characterize this new packet of educational material.

Such titles as "Element'ry, my dear Holmes, element'ry," "Let's Take 2 Minutes to Check," "How Not to Save $300," "Puzzles Are Easy—If One Knows the Answers," all draw attention to the cleverly worded and profusely illustrated pamphlets designed for distribution to the various community groups.

These educational programs are coöperative efforts of local physicians, official health agencies and volunteer citizen groups to find unknown cases of tuberculosis and bring them to treatment; to educate the public on the need for concerted action in order to cut down the toll which this disease takes each year.

The work is supported by the annual sale of Christmas Seals which, this year, opens on November 24.

Undermining Medical Practice.—If it were not so serious, one could derive a certain amount of amusement from the clamor that periodically arises when some branch of medicine is encroached upon by nonprofessionals and is tolerated and even encouraged by the law. In the years gone by ophthalmology has given birth to the optometrist and optician. General practice has sired the physiotherapist. Anesthetists are responsible for the large number of nurses who have intruded into the specialty. There has even been a movement to qualify laymen as "audiometrists" who would be eligible to test hearing with an audiometer.

We, as a whole, have no one but ourselves to blame for this situation. It is a result of carelessness, but more so of indolence in the performance of the time-consuming details attendant upon every branch of medicine. Others have been quick to see the lucrative possibilities of these stepchildren of medicine. They have had our unconscious support in the development of these fields during the past decade and a half, when the medical profession was intense in the encouragement of specialization.

When the world depression began to affect the income of physicians, it began to dawn upon us that we had relinquished a considerable source of revenue which rightly belonged to the doctor. Rectification of the situation was impossible. There are still fields in which there is a tendency to relegate medical functions to laymen. In radiology, dermatology, and orthopedics—to name a few—one sees this inclination all the time. If we are not to be further encroached upon, it is up to us, and us alone, to stop it.—*N. Y. Jour. Med.*, October 1, 1941.

Los Angeles County Examination for Physician.—A $275 a month position in Los Angeles County is seeking a qualified physician to fill it, according to an announcement just made by the Los Angeles County Civil Service Commission.

The position is that of physician, M. D. (communicable disease) in the County Health Department, and the Civil Service Commission has announced an open competitive examination with the usual three-year county residence requirement waived in order to obtain the most competent man for it. Candidates must be not over forty-five years of age, have been graduated from an approved medical school, and have completed a one-year internship in an approved hospital. A residency or second year of internship, including service in a communicable disease unit, is desirable, as is experience in public health work.

Applications to take the examination must be filed with the Los Angeles County Civil Service Commission, Room 102, County Hall of Records, by Wednesday, November 12.

Definition of the Word "Biopsy" Is Given by The Journal of the American Medical Association.—Language is constantly changing, according to *The Journal of the American Medical Association*. The sense of a word in common usage may diverge so far from the dictionary definition that redefinition may be required.

Consider the word "biopsy." The dictionaries agree essentially in defining biopsy as the examination for purposes of diagnosis of a portion of tissue removed from the living body. Usage, however, seems to make "biopsy" mean the process of removing the living tissue rather than the examination. . . .

The following working definition will be followed in the future in the use of the word "biopsy" in publications of the American Medical Association: "The removal and examination of a piece of tissue from the living body for purposes of diagnosis (usually microscopic)." For example, the phrase "biopsy of lymph node" will mean the procedure of removal and examination, and "the biopsy showed . . ." will refer to the results of the examination as part of the whole procedure.

Federal Aid to Schools of Nursing.—Eighty-eight schools of nursing selected by the United States Public Health Service to receive federal aid in training additional student nurses have been named by Surgeon-General Thomas Parran.

Sixty-seven schools in thirty-two states will offer refresher courses to 3,000 graduate nurses, and twenty-six schools will enroll 500 graduate nurses for postgraduate study. A total of $1,200,000 is available for the program, which includes field-training centers for public health nursing.

The student-nurse training program will increase enrollment by 2,000 young women in this country, Hawaii, and Puerto Rico. Surgeon-General Parran has estimated a need for 50,000 student nurses this year, and the federal program will bring the total to about 42,000. The average yearly enrollment is slightly under 40,000. It is hoped schools able to increase their enrollment without federal aid will meet the deficiency. . . .

California schools in the list include: Santa Clara Hospital School of Nursing, San Jose; Los Angeles County General Hospital School of Nursing, Los Angeles.

Pharmacological Items of Potential Interest to Clinicians.—An informal bulletin from the University of California Department of Pharmacology reports:

1. *From Neighboring Americans:* Well-developed new periodical, *Revista Medica Municipal* (Rio de Janeiro) carries neat report by J. Goulart on KCl by mouth for relief of congestive cardiac edema (1:681, 1941). J. Bullo (Rev. Neurol., Buenos Aires, 6:16, 1941) surveys Takata-Ara reaction in cerebrospinal fluid. A. Stabile (Arch. Urug. Med. Cirur. Espec., 18:79, 1941) shows estrone increases tone of insufflated fallopian tubes, while progesterone diminishes it. M. Robortella (Arq. Cirur. Clin. Exper. Sao Paulo, 5: Suppl. 1, 1941), describes significance of Lemos Torres' sign in diagnosing pleural effusion when x-ray is inadequate. B. A. Houssay, E. B. Del Castello, and A. Pinto (Rev. Soc. Argent. Biol., 17:26, 1941) confirm corticosterone inhibition of thymus, finding adrenal cortex extirpation produces thymic and lympathic hyperplasia inhibited by cortex or gonad hormone administration. From Houssay's always productive laboratory comes also a full discussion with Francis S. Smyth and V. G. Foglia of the diabetogenic action of anterior pituitary extracts from different animals (*ibid.*, p. 5). G. C. Bertani (Rev. Aso. Med. Argent., 55:367, 1941) reviews gold therapy in chronic rheumatism. F. F. Rocca and A. G. Falcone (*ibid.*, p. 434) report estrone helpful in hyperthyroidism. For full index of current Latin-American medical periodicals, see back pages of each issue of *Revista Medica Latino-Americana* (Buenos Aires); you may be surprised.

2. *Personal:* Note with regret the death of A. J. Clark, Professor of Pharmacology at Edinburgh, author of useful "Applied Pharmacology" (eighth edition, just issued), and leading contributor to modern pharmacological theory (Mode of Action of Drugs on Cells, Balt., 1933; General Pharmacology, Hdb. Exper. Pharmakol., Erganz. Bd. 4, Berlin, 1937). Clinicians desiring to understand some of the factors involved in "Variations in the Individual Response to Drugs" would do well to read his article of that title (Edin. Med. Surg. J., 42: Trans. Med. Chir. Soc., January, 1935). Available for research contact deserved and desired: Nobel prizeman O. Loewi in New York; P. Pulewka, Professor of Pharmacology at Ankara; Tiffeneau's Parisian associate, M. R. Cahen, in care of P. Vandewiele, Chateauroux, India; E. Starkenstein, Amsterdam; H. Handovsky, Ghent, and A. Rabbeno, Torino. From the Drug Addiction Committee of the League of Nations, P. J. O. Wolff has gone to Buenos Aires. H. H. Anderson and I. Snapper have returned to their posts at Peiping Union Medical College.

3. *Tooting Our Own:* J. G. Hamilton, M. H. Soley, and K. B. Eichorn report on distribution of radio-iodin in human thyroid tissue, showing concentration in hyperplastic areas (Univ. Calif. Publ. Pharmacol., 1:339, 1940). A. Palmer discusses bio-assay of estrogens in ovariectomized mice (*ibid.*, p. 375). J. L. Morrison finds no public health hazard in use of monochloracetic acid as a food and beverage stabilizer (*ibid.*, p. 397). G. A. Alles proposes in comprehensive survey that ionic size is limiting factor in intensity of muscarine or nicotin type of action of alkyl-ammonium ions (*ibid.*, 2:1, 1941). D. F. Marsh reports on anesthetic possibilities of largest single group of potential inhalation anesthetics ever surveyed, forty-eight vinyl type brom and chlor olefins (*ibid.*, 2:39). B. E. Abreu and R. B. Aird discuss disappearance of acacia from cerebrospinal fluid (*ibid.*, 2:79).

4. *Other Notes:* G. Bohmansson and E. B. Norup (Act. Chirur. Scand., 84:427, 1941) report large amounts of serum with sulfonamide greatly improves prognosis in *diffuse* peritonitis, but not in local. G. J. Martin, M. R. Thompson, and J. Carvajal-Foreno (Am. J. Diges. Dis., 8:290, 1941) find that of the vitamin B complex, nicotinamide decreases alimentary tract motility while inositol increases it. H. M. Mackay (Arch. Dis. Child., 16:1, 1941) finds atropin methyl nitrate ("eumydrin") 0.1 to 1 milligram daily in divided doses, with feeding very helpful in hypertrophic pyloric stenosis. In H. H. Kessler's "Accidental Injuries: Medico-Legal Aspects of Workmen's Compensation and Public Liability" (second edition, Philadelphia, 1941), Chapter 19 deals with industrial poisoning, with full bibliography.

Scientific Exhibit at Next Year's Del Monte Annual Session.—Exhibits may consist of charts, graphs, photographs, motion pictures, roentgenograms, specimens, apparatus and instruments. Members of the California Medical Association are invited to correspond with the Secretary-Editor in regard thereto. Prizes and certificates are awarded for the best exhibits.

Tons of Medicine Rushed to U. S. S. R.—Chairman Norman H. Davis of the American Red Cross announced he had given instructions to forward immediately 800 tons of medical supplies now in England to the U. S. S. R. Through the coöperation of the British Red Cross, to which these supplies were consigned, immediate shipment is being made. The supplies will be replaced to the British Red Cross by similar stocks from the United States.

Coincident with this immediate aid to the war-wounded soldiers and civilians in Russia, Chairman Davis announced that an additional $250,000 worth of medical supplies will be sent direct from the United States to Russia. A shipment from this purchase is en route, containing hospital garments, surgical dressings, and large quantities of insulin and gas gangrene serum and antitoxin. The remainder of the $250,000 worth of supplies now is being readied at American ports for shipment. This will include drugs of all types, five million surgical dressings, quantities of surgical instruments and other hospital supplies.

Pay-Your-Doctor Week.—Fourth annual "Pay-Your-doctor Week" was observed this year, November 2 to 8.

Inaugurated in 1938 by California Bank in Los Angeles, observation of "Pay-Your-Doctor Week" swiftly spread to scores of cities throughout the country, and last year virtually achieved nation-wide recognition.

Primary purpose of "Pay-Your-Doctor Week" is to pay tribute to the members of the healing profession, who quietly but relentlessly continue the battle against disease and sickness, particularly at this time when much of the world is engaged in destroying rather than preserving life.

Recognized also is the fairly widespread tendency to "let the doctor wait" until all other bills have been paid.

Sponsors of "Pay-Your-Doctor Week" point out that the plight of the country doctor, who is often paid with farm products or a share in next year's crop, has been widely publicized in recent years, while little has been said about the city doctor, whose reward for services rendered all too frequently consists mainly of long hours of practice and vague promises of payment some time in the future.

Because "Pay-Your-Doctor Week" was originated and is sponsored by the banking profession, the question of medical ethics is not involved.

Banks sponsoring the week throughout the country call attention to the fact that funds are available to lend for the purpose of paying doctor bills.

Hospital Bed Facilities in the United States.—The most widespread survey ever made of hospital bed facilities in the United States has been released by the Census Bureau of the United States Department of Commerce, revealing that 1,282,785 beds were available in 9,614 institutions for the medical care of the American people in 1939.

The country's 6,991 hospitals and sanatoriums provided the great bulk of this care—355,145,063 patient-days, or the equivalent of one week-end stay in a hospital each year for every person in the United States. Infirmaries and nursing, convalescent, and rest homes provided the remainder.

Hospitals and sanatoriums had 1,186,262 beds—92 per cent of the nation's total. Census Bureau figures show that the average hospital had 169 beds and served 5,000 families. . . .

Even existing facilities are not being used fully, the Census Bureau Survey indicated. Allowing a margin of reserve for epidemic peaks, the Committee on the Cost of Medical Care estimated that general hospitals would operate most efficiently with an occupancy of 80 per cent, and mental and tuberculosis hospitals with an occupancy of 90 per cent.

In 1939, general hospitals were operating at 70 per cent of capacity, tuberculosis hospitals at 85 per cent, and mental hospitals at 95 per cent. The Census Bureau noted that many mental hospitals are overcrowded, due to rapidly increasing hospitalization for this type of illness.

Although only 594 hospitals—less than one in ten—were for nervous and mental patients, they had 602,850 beds or more than one-half of the total for all types of patient. They gave 208,466,000 patient-days of care.

The 5,912 general hospitals gave 122,467,000 patient-days of care, and the 485 tuberculosis hospitals 24,212,000 patient-days.

Approximately 77 per cent of the care rendered in 1939 was in state, local, and federal government-controlled hospitals, 20 per cent in nonprofit institutions, and 3 per cent in proprietary institutions, the Census Bureau noted. The large proportion of care financed by taxes is due to government tuberculosis sanatoriums and government hospitals for mental patients.

California was classed with eighteen other states listed as having "adequate facilities," the state being credited with 85,365 beds, equivalent to 124 beds per 10,000 population.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

A Doctor's Job

Several physicians were among the guests at a dinner party at a local home the other evening. Just as dinner was about to be served, one of them received a telephone call and left immediately. Two hours later he returned, in the meantime having performed an emergency operation for appendicitis upon a person he had never seen before. He sat down to a meal that was not so good as it had been a couple of hours earlier.

This little happening is a commonplace sample of what happens constantly in the lives of physicians. Under our present system of privately operated medical practice, physicians are always ready to aid. Somehow we have an idea that if we had some form of state medicine, as is sometimes demanded, state-paid surgeons would not be so ready to sacrifice their comfort for the benefit of their profession.

At least that is usually the way it works when bureaus and bureaucrats take over.—San Jose *News*, October 2.

* * *

Insurance Men Conclude Meet

Convention in San Francisco Goes on Record Against Socialized Medicine

San Francisco.—The current trend toward state-administered medical care and socialized medicine was condemned in San Francisco yesterday by delegates to the twenty-eighth annual convention of the National Fraternal Congress of America, representing eighty-six fraternal insurance societies with a membership of more than seven million.

Concluding its five-day sessions, the convention adopted resolutions advocating prompt and satisfactory solution of the problems of public health and medical care in a manner best befitting the American way of life. . . .

Action of the convention stemmed in part from an address on Wednesday by Charles A. Togut on the political threat to medicine. Mr. Togut, a counselor at law of New York City, warned that state or governmental medicine may destroy the private practice of medicine.

"The paralyzing strangulation of the country's 50,000,000 voters through the politically controlled and dominated doctor will be the lost horizon of merciless bureaucracy," Mr. Togut asserted. "The moment we vest in the Government the care of the body, we imprison the political soul of every voter.

"The legislatures of every state, barring four, pondered over 200 bills relating to medical and hospital care, and several states deliberated far-reaching legislation to establish state-wide plans for public medicine. The Congress of the United States is weighing the destiny of our peoples and of our doctors with numerous authoritarian legislative medical measures. The battle of the century, the Government versus the American Medical Association, is

but a prelude to the conditioning processes of a national planned medical care program—unless the American people, the doctors, the industrialists, the leaders of labor and capital can smother the most powerful propaganda factory in the world and inaugurate fighting means and methods to unite the leaders of medicine and industry in a progressive and universal health insurance movement, the merit of which could not be attacked by the most fervent advocate of socialized medicine."

Organization of a national institute of health insurance under the American Medical Association was advocated by Mr. Togut to make available immediately the medical skill and facilities of the United States to people who cannot buy medical care. Pointing out that a large market awaits this insurance, Mr. Togut said that under full acceptance annual premium income could exceed those of all legal reserve life insurance companies in the United States. . . .

Thomas R. Heaney, Secretary of the Catholic Order of Foresters of Chicago, was elected president of the fraternal congress for the ensuing year.—San Francisco *Wall Street Journal*, September 26.

* * *

Hospital Service Plan Benefits Disclosed

"Payments made to hospitals during this week and covering hospital services for our members brings the total paid out in three years to more than $500,000," reported Ralph G. Walker, executive director of the Associated Hospital Service of Southern California. "This means that this sum, which otherwise would have come out of the savings and pocketbooks of employed people in payment for unexpected hospital bills, has been paid for them through their membership in Southern California's own Hospital Service Plan."

The local Association was organized and backed by fifty-seven hospitals in Southern California.—Hollywood *Citizen-News*, September 26.

* * *

Physicians Seek Better Health Insurance

Ideas for improvement of the major health insurance systems affecting San Francisco physicians were sought at a general meeting of the San Francisco County Medical Society.

The Health Service System, under which 1,070 San Francisco physicians serve 16,274 municipal employees and their dependents, and California Physicians' Service, by which some 5,400 California doctors serve approximately 30,000 persons throughout the state, were analyzed and discussed in detail, according to Dr. Harold A. Fletcher, County Medical Society president.

Means of making these systems function more smoothly and efficiently was given careful consideration by the entire membership of the Society, Doctor Fletcher declared.

"It is vital for the continued existence of the Health Service System that it be put on a sound, businesslike basis," Doctor Fletcher declared. "Under present arrangements, the doctors are required to underwrite this system at an approximate 50 per cent loss to themselves. In justice to the doctors and for the welfare of the system and those it serves, a more efficient basis of operation must be found. The physicians are most earnest in their desire to make this an effective—in fact, a model—health insurance system."

Speakers at Tuesday night's meeting included Dr. Alson R. Kilgore, one of the founders of the California Medical Association's health insurance system.—San Francisco *Sunset News*, September 25.

* * *

Food Sale as Public Utility Is Proposed

San Francisco, September 27 (AP).—An initiative constitutional amendment designating the sale of all food a public utility and vesting in the state the exclusive right to sell food to the public was sent to the Secretary of State today by Avery C. Moore of Oakland, with the request that a copy be forwarded to the Attorney-General for titling.

The proposed amendment would create a state board of food distribution which would purchase food and sell it at cost to the people. It would prohibit food sale by private agency for profit.

Moore said the proposed amendment is intended as a companion initiative to the free medical care initiative, of which he also is the proponent.—Sacramento *Bee*, September 27.

* * *

Warren Rules Relief Camps May Continue

Attorney-General Earl Warren's office today ruled that relief camps established by the defunct State Relief Administration may continue to operate, using supplies already on hand and funds provided by the counties and the Work Projects Administration.

The Medical Practice Act does not require that applicants for licenses as physicians and surgeons, including those holding credentials from foreign medical schools, shall have done all their work in one school. . . .—Sacramento *Bee*, October 10.

* * *

State Health Officers Accused of Failing to Coöperate

Sacramento, October 13 (Special to The News).—A blistering attack on California health officers for failing to coöperate more closely and to arouse greater interest in matters of public health was delivered today by Dr. Lee Alexander Stone, Madera County health officer, at a meeting of the Health Officers' Section, League of California Cities. Doctor Stone, President of the Section, warned that social workers are making inroads in public health fields, are highly organized and, "unless curbed, all of us may find ourselves out on a limb with a social worker directing our actions."

"Save for Bay Region politicians," said Doctor Stone, "I know of no health officer group in California that cares a damn about the welfare of their confrères.

"Doctors as a class are too selfish as far as professional relationships with other groups are concerned. They rarely (there are a few exceptions) interest themselves in what is going on about them except only as it concerns themselves. Their opinions must be regarded as being sacrosanct or else they go into a corner and pout.

"We meet once a year as a health officers' organization. We hear a few papers read and, if interested, enjoy discussing them. We have a good time, give a dry banquet, not because we want to particularly, but because we are afraid of offending reform groups.

"If we are to defeat self-constituted groups bent on taking from us the very little we now have, we should organize.

"Let's forget our own political sensitiveness and determine to have unity for the sole purpose of making the state alive to our existence. Legislation needs to be passed that will place public health and public health officials on a sound economic footing."

* * *

Los Angeles Scientist Gets Coveted British Medical Award

Dr. Arthur E. Guedel Honored for Work in Anesthesia

Dr. Arthur E. Guedel, scientist in the field of anesthesia, last night received the prized Henry Hill Hickman Medal awarded by the Royal Society of Medicine at London. He was the third person in the world and the only American to be so honored.

The presentation, with Gilbert Holliday, British Vice-Consul, acting on behalf of the Royal Society, was made at a dinner tendered Doctor Guedel by the Los Angeles County Medical Association—and was done without the bronze medal itself, "due," Holliday explained, "to unfortunate interruption of shipping schedules."

History Reviewed

Introduced by Dr. Thomas Chalmers Myers, president, Dr. Chauncey Leake, University of California professor of pharmacology, reviewed the history of anesthesia. He described Hickman, a young British surgeon of the last century, as "the first man to undertake, by systematic experiments and study, the use of gases in getting relief from pain in surgical operations."

Doctor Guedel was lauded for "pioneering the reintroduction of nitrous oxid as an anesthetic by making it safe from asphyxiation by adding plenty of oxygen"; for developing divinyl ether—"a safer agent and a faster one than ordinary ether"; for aiding in creation of the carbon dioxid absorption method that "reduces explosions and gives better control to the surgeon," and for twelve years' research in the perfection of cyclopropane gas.—Los Angeles *Press Item*, October 22, 1941.

* * *

Rôle of Mongrel Dogs: A Fat-Burning Hormone Is Discovered

Chicago, October 10 (The Special News Service).—Some mongrel dogs kept at the University of Chicago have helped science discover a new chemical which burns up fat in living bodies.

The chemical is a new hormone, which has been named Lipocaic, after two Greek words, lipos, meaning fat, and kaio, meaning I burn.

This hormone is a companion of insulin. Both are manufactured in the pancreas, the gland which lies near the stomach. Lipocaic is useful in some of the fat disturbances of diabetes, and has cured a few cases of the supposedly incurable skin disease, psoriasis.

In the rôle played by the Chicago dogs, scientific history has repeated itself. Dog experiments enabled the late Sir

Frederick Banting to discover insulin, which has saved millions of lives in a few years.

Live for Science

Whereas laboratory animals popularly are supposed to die for science, the Chicago dogs may be said to have lived for science. All are animals which had gone to the dog catcher and were about to be put to death.

The Chicago experimenters gave these animals new leases on life. One of them, which came into the laboratory when the first experiments began, still is doing his bit.

In these animals, lipocaic was shown to be a good remedy for fatty livers. This is an affliction which sometimes complicates diabetes. One of the first human cases treated for this trouble, a 59-year-old woman, was improved by the new hormone.

Seven Were Cured

The skin disease, psoriasis, was attributed by medical scientists to faulty utilization of fat by the body. For this reason the fat-burner hormone was tried on twenty-two persons. Of these, seven were apparently cured, eleven were improved, and four were not benefited.

The lipocaic has helped another skin trouble, zanthomatisis, in which nodules appear on the body. This disease is attributed to fat in the blood.—San Francisco *Chronicle*, October 11.

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Arrangements Should Be Made in Advance for Children's Clinic

Arrangements should be made in advance for physically handicapped children to attend the clinic in the Veterans' Memorial Building, Sonora, Tuesday, September 23, from 1 to 4 p. m. Appointments can be made through Miss Thelma Jordan, public health nurse.

The clinic is under the auspices of the Crippled Children's Services of the State Department of Public Health.

All children under twenty-one years of age who are crippled by disease, accident, or by deformities present at birth, are eligible to attend the clinic, which is one of a series held annually throughout California by the State Department of Public Health.

Last year the State Department held forty-seven diagnostic clinics in different sections of the state, at which 1,828 crippled children were examined and recommendations made for medical care.—Sonora *Union Democrat*, September 19.

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$75,000 Grant From Rockefeller Foundation Will Finance Three-Year Study of Health Agencies in United States

The National Health Council, which has served for the past two decades as a clearing house for national voluntary organizations promoting better health, is undertaking a comprehensive study of the activities of all private health agencies in the United States, under a special grant of $75,000 from the Rockefeller Foundation, it is announced by Dr. Kendall Emerson, president of the Council.

"Great strides have been made in health education during the past twenty or thirty years," said Doctor Emerson, "and the American public has come to understand that it is much more economical, as well as far more humane, to prevent disease than to cure it. Communities throughout the country have built up many excellent private health services devoted to the prevention of illness, and we have now reached a point where it seems desirable to appraise this whole field of endeavor in order that our efforts may be even more effective.

"The study will take about three years to complete, and the report will answer such broad questions as the following: What are the various types of state and local voluntary health agencies? What fields do they cover? What methods of coöperation with official health agencies have they established? What do they cost to operate? What types of health work lead to the greatest active participation on the part of the citizens?"

Dr. Louis I. Dublin, chairman of a special committee of the National Health Council, which has been making plans for this study, said: "It is particularly appropriate that the Rockefeller Foundation should finance such an undertaking, for it was the support of the Foundation which made possible the establishment of the National Health Council in 1921, and since then the Foundation has shown unmistakable interest in various Council activities. We are especially pleased that the Foundation has met our request to grant a leave of absence to its vice-president, Mr. Selskar M. Gunn, one of the world's outstanding authorities on public health problems, to direct this study."

Mr. Gunn returned to America recently after a long stay abroad as director of the European headquarters of the Rockefeller Foundation in Paris, now closed because of the war. Previously, he had been in charge of the Foundation's program of rural reconstruction in China.

The active members of the National Health Council (headquarters at 1790 Broadway, New York City), include the following: American Red Cross, American Public Health Association, American Eugenics Society, American Heart Association, American Social Hygiene Association, American Society for the Control of Cancer, American Society for the Hard of Hearing, Conference of State and Provincial Health Authorities of North America, Maternity Center Association, National Committee of Health Council Executives, National Committee for Mental Hygiene, National Organization for Public Health Nursing, National Society for the Prevention of Blindness, and the National Tuberculosis Association.

There are two associate members, the American Nurses' Association and the Foundation for Positive Health; and there are two advisory members, the United States Children's Bureau, and the United States Public Health Service.

MEDICAL EPONYM

Bence-Jones Protein

A paper, "On a new substance occurring in the Urine of a patient with Mollities Ossium," was read before the Royal Society on April 22, 1847, by Henry Bence-Jones (1813-1873), physician to St. George's Hospital. This appears in the *Philosophical Transactions of the Royal Society of London* (138, Pt. 1:55-62, 1848).

On the 1st of November 1845 I received from Dr. *Watson* the following note, with a test tube containing a thick, yellow, semi-solid substance:—'The tube contains urine of very high specific gravity; when boiled it becomes highly opake; on the addition of nitric acid it effervesces, assumes a reddish hue, becomes quite clear, but, as it cools, assumes the consistence and appearance which you see: heat reliquifies it. What is it?'

"A few hours afterward a specimen of the same urine, passed by a grocer forty-seven years of age, who had been out of health for thirteen months, was sent to me by Dr. *MacIntyre*. He, being in attendance on the case with Dr. *Watson*, had two days previously first observed the peculiar reactions of the urine.

"The specimen of urine was slightly acid; specific gravity 1.034; it contained a sediment consisting of crystalline phosphate of lime, oxalate of lime, and cylinders of fibrin. The urine became thick with heat from a deposit of phosphates, but cleared with a drop of acid. It gave no precipitate with an excess of nitric acid, unless left to stand, or unless heated and left to cool, when it became solid. This solid redissolved by heat, and again formed on cooling. Continued boiling with strong nitric acid evolved but little gas, and did not quickly hinder this reaction. Hydrochloric acid gave the same solid precipitate, soluble by heat. Strong acetic acid gave only a slight precipitate which redissolved by heat. Caustic potash and sulphate of copper gave a splendid bright blue, clear liquid, passing over when heated to claret colour. . . .

"January 2nd.—The patient died. The following day I saw that the bony structure of the ribs was cut with the greatest ease, and that the bodies of the vertebrae were capable of being sliced off with the knife. For an account of the structure of the bone, see a paper by Mr. *Dalrymple* in the third number of the Dublin Journal, August 1846. . . .

"The ultimate analysis of this substance may be represented by C_{48}, H_{37}, N_6, O_{15} or C_{40}, H_{30}, N_5, O_{12}. . . . Hence it is an oxide of albumen, and from ultimate analysis, it is the hydrated deutoxide of albumen. . . .

"The peculiar characteristic of this hydrated deutoxide of albumen was its solubility in boiling water, and the precipitate with nitric acid being dissolved by heat and reformed when cold. . . .

This substance must again be looked for in acute cases of mollities ossium. The reddening of the urine on the addition of nitric acid might perhaps lead to the rediscovery of it. . . ."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 9.

LETTERS†

Concerning Inactive Duty Training: Medical Department Reserve Officers.

(COPY)

HEADQUARTERS NORTHERN CALIFORNIA MILITARY DISTRICT
PRESIDIO OF SAN FRANCISCO, CALIFORNIA

October 28, 1941.

Subject: Inactive Duty Training, Medical Department Officers, 1941-42.

To All Medical, Dental, Veterinary, Sanitary and Medical Administrative Officers in the Northern California Military District.

1. In keeping with the policy of the War Department, for inactive duty training, during the school year 1941-42, all medical department reserve officers are enjoined to participate with the view in mind to increase their military knowledge. In this connection attention is invited to the fact that the Combined East and West Bay Special Medical School meets once a month:

Place: Building 612 (usual classroom) Presidio of San Francisco, California.

Date: Third Tuesday of each month.

Hours: 7:30 p. m. to 9:30 p. m.

2. Programs are arranged in advance, and excellent speakers are obtained. Lecture, conference and applicatory methods are used and from time to time visual methods are also employed. In these days of national emergency no officer concerned can afford to miss the available instructions.

3. Due consideration has been given to your busy personal program; however, today military obligations have priority. Concerned officers not yet called to active duty should set aside without fail the evening of the *third Tuesday* of each month for the 1941-42 school year, and officers now on active duty who can attend without interfering with their duties are cordially invited to be present.

(Signed) HAROLD R. HENNESSY,
Major, Medical Corps Unit Instructor.

Concerning California Laws in re Foreign Medical Graduates.*

(COPY)

BOARD OF MEDICAL EXAMINERS: STATE OF CALIFORNIA

San Francisco, California,
October 7, 1941.

Yours of October 3, re Dr. ———, Foreign Medical School Graduate.

Dear Doctor:

This will acknowledge receipt of your letter written in behalf of Dr. ———, who you state is a graduate of a medical college in Czecho-Slovakia.

The 1941 legislature passed Chapter 751, Statutes 1941, wherein, among other requirements exacted of foreign medical school graduates, is one reading in part as follows:

"If the applicant is not a citizen of the United States (it will be necessary for him to show satisfactory evidence that) the country in which he has been admitted to practice medicine and surgery will admit to practice therein citizens of the United States, upon proof of prior admission to practice medicine and surgery in some state of the United States, or upon proof of matters similar to those required in this section for graduates of foreign medical schools."

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Trusting that this is the information you desire, believe me

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C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Concerning Official Agencies in Civilian Defense.*

(COPY)

Executive Office of the President
OFFICE FOR EMERGENCY MANAGEMENT
WASHINGTON, D. C.

OFFICE OF CIVILIAN DEFENSE
233 Sansome Street, San Francisco
Telephone: EXbrook 2751

October 1, 1941.

To the Editor:—I am enclosing a copy of Doctor Baehr's letter and the joint statement of the Office of Civilian Defense and the Red Cross. We would appreciate your printing any or all of it in CALIFORNIA AND WESTERN MEDICINE. Doctor Baehr thought the second paragraph of his letter, without the introductory phrase, would be sufficient, but you can use your own judgment. Use as much or as little of it as you see fit.

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Cordially,

(Signed) WALLACE D. HUNT, M. D.,
Regional Medical Officer.

* * *

(COPY)

OFFICE OF CIVILIAN DEFENSE
WASHINGTON, D. C.

September 22, 1941.

To Chairmen, State Defense Councils
Attention: Health and Medical Committees

Numerous requests have been received by the Medical Division of the Office of Civilian Defense from Health and Medical Committees of state and local defense councils for a definition of the rôle of Red Cross Chapters in the local program. The enclosed statement, issued jointly on September 4 by the U. S. Director of Civilian Defense and the Chairman of the American National Red Cross, supplies this information. I would request that this joint statement be transmitted to your local defense councils and local Chiefs of Emergency Medical Service.

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2. The American National Red Cross is the responsible agency for relief of suffering caused by disaster, both in peacetime and in the national defense emergency, by providing food, clothing, shelter, medical and nursing care, and other basic necessities. Therefore, Red Cross Disaster Relief Service, nationally and in local chapters, will serve in emergency care and rehabilitation of individuals and families suffering from disaster caused by belligerent action during the national defense emergency in coöperation with governmental agencies—national, state, and local. In rescue work and emergency medical service caused by belligerent action by which the Office of Civilian Defense assumes leadership and responsibility, the Red Cross will make its services available as needed. (See "Disaster Preparedness and Relief—Manual for Chapters," ARC 209, issued by the American Red Cross.)

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U. S. Director, Civilian Defense.
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MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Releases: Effect of Release Given by Injured Employee to Employer and Insurance Carrier; Release Does Not Preclude Malpractice Action

It is a general rule of law that a release given by an injured person to one of several persons jointly causing his injury has the effect of releasing all persons. Usually the rule is stated as follows: "The release of one joint tort feasor releases all." As so-called malpractice actions are tort actions, it follows that where more than one person is claimed to have caused injury to a patient, a release given to one releases all. (For a more detailed discussion, see CALIFORNIA AND WESTERN MEDICINE, August, 1938, p. 171.)

The following is a hypothetical case illustrating the foregoing rule: Mr. X undergoes a major operation at the White Hospital (not a charitable hospital); surgery is performed by Dr. A, who is assisted by several nurses employed by the hospital. One nurse neglects properly to count the sponges, resulting in a sponge being left in the patient's body. Assuming negligence, the persons liable would be Dr. A, as the surgeon, the nurse, and the White Hospital. If the patient, Mr. X, should sign a written release releasing the nurse, such release would also have the effect of releasing both the physician and the hospital.

A far different situation is present in those instances in which negligence is involved in the treatment of an employee injured during the course of his employment. An injured employee has, of course, a right to claim compensation under the Workmen's Compensation Act against his employer and his employer's insurance carrier. Under the Compensation Act, if the original injury is aggravated because of medical treatment furnished at the expense of the employer or his insurance carrier, the injured employee may claim additional compensation for such aggravated injury.

Assuming that an injured employee is negligently treated by a physician selected by his employer's insurance carrier, and assuming that such treatment aggravates the original injury, then the question arises: If the injured employee releases his employer and insurance carrier from liability under the Workmen's Compensation Act, does such release also operate as a release of the physician?

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The decision of the Court was based upon the fact that the physician and the employer and insurance carrier were not *joint* tort feasors. The employer and insurance carrier were not in any manner liable in tort for the act of the physician. Their liability was one for compensation under the Workmen's Compensation Act, which is a special liability not dependent upon negligence or wrong. Accordingly, the release of the employer and insurance carrier was not a release of a liability for tort and, hence, could not inure to the benefit of the physician, whose liability, if any, was necessarily a tort liability.

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LETTERS†

Concerning Inactive Duty Training: Medical Department Reserve Officers.

(COPY)

HEADQUARTERS NORTHERN CALIFORNIA MILITARY DISTRICT
PRESIDIO OF SAN FRANCISCO, CALIFORNIA

October 28, 1941.

Subject: Inactive Duty Training, Medical Department Officers, 1941-42.

To All Medical, Dental, Veterinary, Sanitary and Medical Administrative Officers in the Northern California Military District.

1. In keeping with the policy of the War Department, for inactive duty training, during the school year 1941-42, all medical department reserve officers are enjoined to participate with the view in mind to increase their military knowledge. In this connection attention is invited to the fact that the Combined East and West Bay Special Medical School meets once a month:

Place: Building 612 (usual classroom) Presidio of San Francisco, California.

Date: Third Tuesday of each month.

Hours: 7:30 p. m. to 9:30 p. m.

2. Programs are arranged in advance, and excellent speakers are obtained. Lecture, conference and applicatory methods are used and from time to time visual methods are also employed. In these days of national emergency no officer concerned can afford to miss the available instructions.

3. Due consideration has been given to your busy personal program; however, today military obligations have priority. Concerned officers not yet called to active duty should set aside without fail the evening of the *third Tuesday* of each month for the 1941-42 school year, and officers now on active duty who can attend without interfering with their duties are cordially invited to be present.

(Signed) HAROLD R. HENNESSY,
Major, Medical Corps Unit Instructor.

Concerning California Laws in re Foreign Medical Graduates.*

(COPY)

BOARD OF MEDICAL EXAMINERS: STATE OF CALIFORNIA

San Francisco, California,
October 7, 1941.

Yours of October 3, re Dr. ———, Foreign Medical School Graduate.

Dear Doctor:

This will acknowledge receipt of your letter written in behalf of Dr. ———, who you state is a graduate of a medical college in Czecho-Slovakia.

The 1941 legislature passed Chapter 751, Statutes 1941, wherein, among other requirements exacted of foreign medical school graduates, is one reading in part as follows:

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TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIV, No. 11, November, 1916

EXCERPTS FROM EDITORIAL NOTES

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The first point here may be answered by saying that the object of requiring a payment for each of two consecutive years, cash for the first payment and the note for the second, is to maintain the interest of the contributors in the first place, and in the second, to distribute the money payment over two years and not concentrate it in one payment of $30.

The second question may be answered by saying that a promissory note, to be a negotiable document, must be an unconditional promise to pay a certain sum of money to order of bearer. Any alteration of the form of the note immediately destroys its negotiability. . . .

(Continued in Front Advertising Section, Page 16)

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By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

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"Shortly before he was to be sworn in as a medical officer in the United States Navy, Dr. Walter W. Webb, thirty-five, formerly of Seattle, was arrested in Vallejo yesterday by Federal narcotics officers on charges of selling drugs. In a removal complaint filed before United States Commissioner Ernest E. Williams by Assistant United States Attorney James T. Davis, Webb was charged with sales of morphin and cocain in Seattle between last June 28 and July 1. He was brought to San Francisco County jail and held in lieu of $1,000 bail." (San Francisco *Examiner*, September 7, 1941.)

"Christopher North received a five months' sentence in the county jail Friday, after being convicted by Judge J. G. Null on a charge of practicing chiropody without a license. . . ." (Redding *Record*, September 13, 1941.)

"The state prison board has notified Superior Judge Gordon Thompson that Dr. George H. Parchen, former local chiropractor, and his brother, Frank McKinley Parchen, must serve fifteen years in San Quentin prison. They were convicted here of second-degree murder and participation in an illegal operation. In July, 1939, Thompson sentenced them to indeterminate sentences. . . ." (San Diego *Tribune-Sun*, September 17, 1941.)

"Special Agents for the State Medical Board yesterday charged two men with practicing medicine without a license. They were Eugene L. Thurston, fifty-nine, of 610 Hyde Street, and Henry A. Jotz, thirty-five, 889 Geary Street. . . ." (San Francisco *Examiner*, September 13, 1941.) Thereafter the San Francisco *Chronicle* of September 30 carried a notice of the suicide of Thurston.

"Dr. Carl G. Williams, Santa Monica physician, will be arraigned in Department 41 of the Superior Court Monday on a charge of assault with a deadly weapon. Doctor Williams, accused of firing a pistol at a housemaid, and an attorney, and later holding at bay a group of West Los Angeles policemen when they answered a call to his home at 580 Moreno Avenue, Brentwood, was held to answer to the superior court after a preliminary hearing in West Los Angeles municipal court. . . ." (Santa Monica *Outlook*, September 27, 1941.)

(Continued in Back Advertising Section, Page 30)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

EVER FEED SMA*?

When you prescribe S.M.A. for the bottle-fed infant you give an easily digested fat, a protein that provides the amino acids essential for adequate nutrition and growth and *lactose*, a physiological carbohydrate, in correct proportion to the nutritional requirements of the normal full-term infant.

In addition, when prepared according to the usual dilution for feeding, each quart of S.M.A. contains:

7500 international units vitamin A activity
200 international units vitamin B_1
400 international units vitamin D
10 mg. Iron and Ammonium Citrate

S.M.A. provides easily digested fat and protein of full biological value in correct proportion to the nutritional requirements of the normal full term infant. Therefore, the only carbohydrate in S.M.A. is Lactose . . .

Normal infants relish S.M.A. . . . digest it easily and thrive on it.

" " "

FOR PREMATURE AND UNDERNOURISHED INFANTS

A Special Product

PROTEIN S.M.A.

(Acidulated)

Protein S.M.A. (acidulated) is a modified form of S.M.A., intended to meet the special nutritional needs of the premature and undernourished infant and for infants requiring a high protein intake.

Protein S.M.A. (acidulated) is similar to both casein milk and lactic acid milk, but presents additional nutritional elements lacking in both.

*S.M.A., a trade mark of S.M.A. Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrates and ash, in chemical constants of the fat and physical properties.

ACCEPTED AMERICAN MEDICAL ASSN. Commodities on Foods

S.M.A. CORPORATION • 8100 McCORMICK BOULEVARD • CHICAGO, ILLINOIS

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News

"Federal Judge Michael J. Roche discharged a jury in the trial of C. A. Isbell and Mr. and Mrs. Fred Mandeville of Colfax, Placer County, on charges of using the mails to defraud, when it was unable to reach a verdict after deliberating for nearly three hours. The retrial date will be set for October 6. The defendants were accused of using the mails to advertise a cure-all for cancer, diabetes, venereal diseases and other ailments. . . ." (Sacramento *Bee*, September 18, 1941.)

"Shortly before he was to be sworn in as a medical officer in the United States Navy, Dr. Walter W. Webb, thirty-five, formerly of Seattle, was arrested in Vallejo yesterday by Federal narcotics officers on charges of selling drugs. In a removal complaint filed before United States Commissioner Ernest E. Williams by Assistant United States Attorney James T. Davis, Webb was charged with sales of morphin and cocain in Seattle between last June 28 and July 1. He was brought to San Francisco County jail and held in lieu of $1,000 bail." (San Francisco *Examiner*, September 7, 1941.)

"Christopher North received a five months' sentence in the county jail Friday, after being convicted by Judge J. G. Null on a charge of practicing chiropody without a license. . . ." (Redding *Record*, September 13, 1941.)

"The state prison board has notified Superior Judge Gordon Thompson that Dr. George H. Parchen, former local chiropractor, and his brother, Frank McKinley Parchen, must serve fifteen years in San Quentin prison. They were convicted here of second-degree murder and participation in an illegal operation. In July, 1939, Thompson sentenced them to indeterminate sentences. . . ." (San Diego *Tribune-Sun*, September 17, 1941.)

"Special Agents for the State Medical Board yesterday charged two men with practicing medicine without a license. They were Eugene L. Thurston, fifty-nine, of 610 Hyde Street, and Henry A. Jotz, thirty-five, 889 Geary Street. . . ." (San Francisco *Examiner*, September 13, 1941.) Thereafter the San Francisco *Chronicle* of September 30 carried a notice of the suicide of Thurston.

"Dr. Carl G. Williams, Santa Monica physician, will be arraigned in Department 41 of the Superior Court Monday on a charge of assault with a deadly weapon. Doctor Williams, accused of firing a pistol at a housemaid, and an attorney, and later holding at bay a group of West Los Angeles policemen when they answered a call to his home at 580 Moreno Avenue, Brentwood, was held to answer to the superior court after a preliminary hearing in West Los Angeles municipal court. . . ." (Santa Monica *Outlook*, September 27, 1941.)

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† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.